HUMANA.
Guidance when you need it most

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Humana Medicare Employer PPO

This booklet gives you the details about your Medicare health coverage. It explains how to get the health care you need. This is an important legal document. Please keep it in a safe place.

Humana Medicare Employer PPO Customer Care Team:
For help or information, please call the Customer Care Team at the number on the back of your membership card. You can call seven days a week from 8 a.m. to 8 p.m. Calls to these numbers are free. You may also go to our Plan Website at **Humana.com.**

This Plan is offered by Humana Insurance Company / Humana Health Insurance Company of Florida, Inc. / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. / Humana Medicare Employer PPO, referred throughout the *Evidence of Coverage* as "we," "us," or "our". Humana Medicare Employer PPO is referred to as "plan" or "our plan."

Our plan is a PPO plan with a Medicare contract.

This information may be available in a different format, including Spanish, large print, and audio tapes. Please call the Customer Care Team at the number on the back of your membership card if you need plan information in another format or language.

Esta informacion esta disponible en otro formato, incluyendo en ingles, en letra grande o en cintas de audio. Si necesita informacion del plan en otro idioma o en otro formato, llame al Equipo de Atencion al Cliente (los numeros de telefono pueden encontrarse en el reverso de su tarjeta de afiliacion).

Table of Contents

This list of chapters and page numbers is just your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1. Getting started as a member of Humana Medicare Employer PPO

SECTION 1 Introduction

What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

- You are covered by Medicare, and your Medicare health care coverage through our plan, Humana Medicare Employer PPO.

- There are different types of Medicare Advantage Plans. Humana Medicare Employer PPO is a Medicare Advantage Plan PPO (PPO stands for Preferred Provider Organization).

This Plan is offered by Humana Insurance Company / Humana Health Insurance Company of Florida, Inc. / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. / Humana Medicare Employer PPO, referred throughout the *Evidence of Coverage* as "we," "us," or "our". Humana Medicare Employer PPO is referred to as "plan" or "our plan."

The word "coverage" and "covered services" refers to the medical care and services available to you as a member of Humana Medicare Employer PPO.

What does this Chapter tell you?

Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- What is your plan's service area?
- How do you keep the information in your membership record up to date?

What if you are new to Humana Medicare Employer PPO?

If you are a new member, then it's important for you to learn how the plan operates - what the rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our Customer Care Team (telephone number on the back of your membership card).

Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Humana Medicare Employer PPO covers your care. Other parts of this contract include your enrollment form, and any notices you receive from us about changes or extra conditions that can affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Humana Medicare Employer PPO coverage.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve Humana Medicare Employer PPO each year. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Your eligibility requirements

You are eligible for membership in our plan as long as:

- You live in our geographic service area (Chapter 1, Section 6 describes our service area)
- -- *and* -- you are entitled to Medicare Part A
- -- *and* -- you are enrolled in Medicare Part B

What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by providers such as hospitals, skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services, such as physician's services and other outpatient services.

SECTION 3 What other materials will you get from us?

Your plan membership card - Use it to get all covered care

Now that you are a member of our Plan, you must use our membership card for services covered by this plan. While you are a member of our Plan and using our Plan services, you *must* use your plan membership card instead of your red, white, and blue Medicare card to get covered services and items. (See Chapter 4 for information on covered services.) Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered services and items. If your membership card is damaged, lost, or stolen, call the Customer Care Team right away and we will send you a new card.

The *Provider Directory*: your guide to all providers in the plan's network

Every year that you are a member of our plan, we will send you either a new *Provider Directory* or an update to your *Provider Directory.* This directory lists our contracted providers.

What are "Contracted providers"?

Contracted providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment in full. We have arranged for these providers to deliver covered services to members in our plan.

Why do you need to know which providers are part of our network?

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (Using the plan's coverage for your medical services) for more specific information.

If you don't have your copy of the *Provider Directory* , you can request a copy from the Customer Care Team (telephone number on the back of your membership card). You may ask the Customer Care Team for more information about our contracted providers, including their qualifications.

SECTION 4 Your monthly premium for Humana Medicare Employer PPO

How much is your plan premium?

If you have a plan premium, please contact your plan sponsor for instructions on how to make payment.

Your coverage is provided through a contract with your plan sponsor, who may be your current employer or former employer or union. Please contact your plan sponsor for information about your plan premium.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B. You must continue paying your Medicare Part B premium for you to remain as a member of the plan.

- Your copy of *Medicare & You 2011* tells about these premiums in the section called "2011 Medicare Costs." This explains how the Part B premium differs for people with different incomes.

- Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2011* from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

SECTION 5 Please keep your plan membership record up to date

How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These contracted providers use your membership record to know what services are covered for you**. Because of this, it is very important that you help us keep your information up to date.

Call the Customer Care Team to let us know about these changes:

- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call the Customer Care Team (telephone number on the back of your membership card).

SECTION 6 The Geographic Service Area for our Plan

Here is the plan service area for Humana Medicare Employer PPO

Although Medicare is a Federal program, Humana Medicare Employer Regional PPO is available only to individuals who live in our plan service area. To stay a member of our plan, you generally must keep living in this service area.

We offer coverage in several states and territories. If the address you have on file with PEIA, does not match the address on file with Medicare, Humana will send you an address verification form. It is important to complete this form to avoid any issues with your medical coverage.

All address changes should be submitted in writing to the following address:
PEIA
601 57th Street SE, Ste. 2
Charleston, WV 25305

If you plan to move out of the service area, please contact Customer Care Team.

The service area is described below:

Where is Humana Medicare Employer PPO available?

This plan is available in all municipalities and counties in the following states: **Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming:** You must live in one of these states or municipalities to join the plan.

Chapter 2. Important phone numbers and resources

SECTION 1 Humana Medicare Employer PPO contacts (how to contact us, including how to reach Customer Care Team at the plan)

How to contact our plan's Customer Care Team

For assistance with claims, billing or member card questions, please call or write to Humana Medicare Employer PPO Customer Care Team. We will be happy to help you.

Customer Care Team	
CALL	1-800-783-4599
TTY	**711** This number requires special telephone equipment. Calls to this number are free.
WRITE	P.O. Box 14168 Lexington, KY 40512-4168
WEBSITE	**Humana.com**

How to contact us when you are asking for a coverage decision about your medical care

You may call us if you have questions about our coverage decision process.

Coverage Decisions for Medical Care	
CALL	1-866-737-5113 Call Customer Care Team at the telephone number on the back of your membership card outside of regular weekday business hours. Calls to this number are free.
TTY	**711** This number requires special telephone equipment. Calls to this number are free.
WRITE	Humana Correspondence, P. O. Box 14601, Lexington, KY 40512-4601

For more information on asking for coverage decisions about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

How to contact us when you are making an appeal about your medical care

Appeals for Medical Care	
CALL	Customer Care Team at the telephone number on the back of your membership card to request a standard appeal. 1-800-867-6601 to request an expedited appeal. Calls to this number are free.
TTY	**711** This number requires special telephone equipment. Calls to this number are free.
FAX	1-800-949-2961 for expedited appeals only.
WRITE	Humana Grievance and Appeal Dept., P.O. Box 14165, Lexington, KY 40512-4165

For more information on making an appeal about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

How to contact us when you are making a complaint about your medical care

Complaints about Medical Care	
CALL	Customer Care Team at the telephone number on the back of your membership card. 1-800-867-6601 for an expedited grievance. Calls to this number are free.
TTY	**711** This number requires special telephone equipment. Calls to this number are free.
FAX	1-800-949-2961 for expedited grievances only.
WRITE	Humana Grievance and Appeal Dept., P. O. Box 14165, Lexington, KY 40512-4165

For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Where to send a request that asks us to pay for our share of the cost for medical care you have received

For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking the plan to pay its share of a bill you have received for medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Payment Requests

CALL	Call the telephone number on the back of your membership card. Calls to this number are free.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Humana Correspondence PO Box 14601 Lexington, KY 40512-4601

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).
The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with and regulates Medicare health plans including Humana Medicare Employer PPO.

Medicare

CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

WEBSITE http://www.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "Helpful Phone Numbers and Websites."

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

The State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

State Health Insurance Assistance Program (SHIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. State Health Insurance Assistance Program (SHIP) counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

You may find contact information for the SHIP in your state in the state specific data sheets at the end of this Evidence of Coverage.

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization (QIO) in each state.

The Quality Improvement Organization (QIO) has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. The Quality Improvement Organization (QIO) is an independent organization. It is not connected with our plan.

You should contact your Quality Improvement Organization (QIO) in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

You can find contact information for the QIO in your state in the state specific data sheets at the end of this Evidence of Coverage.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or end stage renal disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare and pay the Part B premium. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security Administration

CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use our automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	http://www.ssa.gov

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact your state Medicaid office.

To find out more about Medicaid and its programs, refer to the state specific data sheets at the end of this Evidence of Coverage.

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board

CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	http://www.rrb.gov

Chapter 3. Using the plan's coverage for your medical services

SECTION 1 Things to know about getting your medical care as a member of our plan

This chapter tells things you need to know about using the plan to get your medical care coverage. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay as your share of the cost when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical benefits chart, what is covered and what you pay*).

What are "contracted providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals that the state licenses to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.

- **"Contracted providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a contracted provider, you usually pay only your share of the cost for their services.

- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Basic rules for getting your medical care that is covered by the plan

Humana Medicare Employer PPO will generally cover your medical care as long as:

- The care you receive is included in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet).

- The care you receive is considered medically necessary. It needs to be accepted treatment for your medical condition.

- You receive your care from a provider who participates in Medicare. As a member of our plan, you can receive your care from either a contracted provider or an out-of-network provider (for more about this, see Section 2 in this chapter).

    - The providers in our network are listed in the *Provider Directory* .

    - **Please note:** While you can get your care from an out-of-network provider, the provider must participate in Medicare. We cannot pay a provider who has decided not to participate in Medicare. You will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they have not opted out of Medicare.

SECTION 2 Using network and out-of-network providers to get your medical care

How to get care from specialists and other contracted providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists, who care for patients with cancer.
- Cardiologists, who care for patients with heart conditions.
- Orthopedists, who care for patients with certain bone, joint, or muscle conditions.

We list the providers that participate with our plan in our Provider Directory. While you are a member of our plan you may use either contracted providers or out-of-network providers. See Chapter 4, Medical benefits chart (what is covered and what you pay) for more information on what your costs will be. You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to confirm with us that the services you are getting are covered by us and are medically necessary. If an out-of-network provider sends you a bill that you think we should pay, refer to Chapter 5 (Asking the plan to pay its share of a bill you have received for covered services) for information on how to ask us to pay that bill for you. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay.

It is best to ask an out-of-network provider to bill us first, but if you have already paid for the covered services, we will reimburse you for our share of the cost. (Please note that we cannot pay a provider who has opted out of the Medicare program. Check with your provider before receiving services to confirm that they have not opted out of Medicare.) If we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost.

What if a specialist or another contracted provider leaves our plan?

Sometimes a specialist, clinic, hospital or other contracted provider you are using might leave the plan. If there is a change in your provider network, we will send you a letter notifying you of the change 30 days prior to the provider's date of termination. The notification describes the changes in your provider network and the effective date of the change. The written notification will contain specific information, depending on the type of provider that is leaving the network.

How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. Here are important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, that provider must participate in Medicare. We cannot pay a provider who has decided not to participate in Medicare. You will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they have not opted out of Medicare.

- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to call the Customer Care Team to tell us you are going to use an out-of-network provider and to confirm that the services you are getting are covered and are medically necessary. This is important because:

    - If we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 *(What to do if you have a problem or complaint)* to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (*Asking the plan to pay its share of a bill you have received for medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.

SECTION 3 How to get covered services when you have an emergency or urgent need for care

Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?
When you have a "medical emergency," you believe that your health is in serious danger. A medical emergency can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.

- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours.

- Call the telephone number on the back of your ID card.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it from any provider or facility. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the medical benefits chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by non-network providers, we will try to arrange for contracted providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care thinking that your health is in serious danger - and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, the amount of cost-sharing that you pay will depend on whether you get the care from contracted providers or out-of-network providers. If you get the care from contracted providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Getting care when you have an urgent need for care

What is "urgently needed care"?
"Urgently needed care" is a non-emergency situation when:

- You need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger.
- Because of the situation, it isn't reasonable for you to obtain medical care from a contracted provider.

What if you are <u>outside</u> the plan's service area when you have an urgent need for care?

Suppose that you are temporarily outside our plan's service area, but still in the United States. If you have an urgent need for care, you probably will not be able to find or get to one of the providers in our plan's network. In this situation (when you are outside the service area and cannot get care from a contracted provider), our plan will cover urgently needed care that you get from any provider at the in-network cost-sharing amount.

SECTION 4 What if you are billed directly for the full cost of your covered services?

You can ask the plan to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you will want our plan to pay our share of the costs by reimbursing you for payments you have already made.
There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us so that we can pay our share of the costs for your covered medical services.

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking the plan to pay its share of a bill you have received for medical services or drugs*) for information about what to do.

If services are not covered by our plan, you must pay the full cost

Humana Medicare Employer PPO covers all medical services that are medically necessary, are covered under Medicare, and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call the Customer Care Team at the telephone number on the back of your membership card to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Paying for costs once a benefit limit has been reached will not count toward your out-of-pocket maximum. You can call the Customer Care Team when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

What is a "clinical research study"?

A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, *you will be responsible for paying all costs for your participation in the study*. Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan. If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from our plan or your provider. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.
3. We can keep track of the health care services that you receive as part of the study.

If you plan on participating in a clinical research study, contact the Customer Care Team (see Chapter 2, Section 1 of this *Evidence of Coverage*).

When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, **Medicare will pay for the covered services you receive as part of the research study.** Medicare pays for routine costs of items and services. Examples of these items and services include the following:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

When you are part of a clinical research study, **Medicare will *not* pay for any of the following**:

- Generally, Medicare will not pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were not in a study.

- Items and services the study gives you or any participant for free.

- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your condition would usually require only one CT scan.

You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive as a participant in the clinical research study. Because you are a member of our plan, you *do not* have to pay the deductibles for Original Medicare Part A or Part B.

Do you want to know more?

To find out what your coinsurance would be if you joined a Medicare-approved clinical research study, please call the Customer Care Team (telephone number on the back of your membership card).

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (http://www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care in a "religious non-medical health care institution"

What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, you must elect to have your coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following condition applies:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.

You are covered for an unlimited number of medically necessary inpatient hospital days. See chapter 4.

Chapter 4. Medical benefits chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that gives a list of your covered services and tells how much you will pay for each covered service as a member of Humana Medicare Employer PPO. Later in this chapter, you can find information about medical services that are not covered. It also tells about limitations on certain services if applicable.

What types of out-of-pocket costs do you pay for your covered services?

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The **"deductible"** means the amount you must pay for medical services before our plan begins to pay its share

- A **"copayment"** means that you pay a fixed amount each time you receive a medical service. You pay a copayment at the time you get the medical service

Some people qualify for programs to help them pay their out-of-pocket costs for Medicare. If you are enrolled in these programs, you may still have to pay the Medicaid copayment, depending on the rules in your state.

What is the maximum amount you will pay for certain covered medical services?

There is a limit to how much you have to pay out-of-pocket for certain covered health care services each year. After this level is reached, you will have 100% coverage and not have to pay any out-of-pocket costs for the remainder of the year for covered services. You will have to continue to pay your premium if your plan has a premium.

- During the year, if the amount that you spend on your deductible, copayments as a member of this plan goes over $750 for combined in-network and out-of-network services, you will pay no further cost-share for in-network and out-of-network services for the remainder of the policy.

NOTE: Please refer to the Medical Benefits Chart for services that do not apply toward your combined in-network and out-of-network out-of-pocket maximum and you continue to pay your cost-share

Paying your share of the cost when you get covered services

The "deductible" is the amount you must pay for the health care services you receive before our Plan begins to pay its share of your covered services. There is a $25 annual deductible. Please refer to the following **benefits** chart for services that are excluded from your annual deductible.

SECTION 2 Use this *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Your medical benefits and costs as a member of the plan

The medical benefits chart on the following pages lists the services Humana Medicare Employer PPO covers and what you pay for each service. The services listed in the Medical Benefits Chart are covered only when all coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare
- Except in the case of preventive services and screening tests, your services (including medical care, services, supplies, and equipment) *must* be medically necessary. Medically necessary means that the services are an accepted treatment for your medical condition
- Some of the services listed in the Medical Benefits Chart are covered as in-network services only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from Humana Medicare Employer PPO.
    - You never need approval in advance for out-of-network services from out-of-network providers.
    - While you don’t need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
    - Covered services that need approval in advance to be covered as in-network services are marked by a footnote in the Medical Benefits Chart. In addition, the following services not listed in the Benefits Chart require approval in advance:
        - Automatic Implantable Cardioverter Defibrillators (AICD)
        - Pain Management Procedures
        - Hyperbaric Therapy
        - Infertility Testing and Treatment
        - Uvulopalatopharyngoplasty (UPPP)
        - Varicose Vein: Surgical Treatment and Sclerotherapy
        - Ventricular Assist Devices

Services that are covered for you	**What you must pay** when you get these services
Inpatient Care	
Inpatient hospital care You are covered for unlimited number of days for medically necessary services. Covered services include, but aren't limited to, the following: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units (such as intensive or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical therapy, occupational therapy, and speech therapy • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Travel reimbursement requires a minimum of 100 miles one way to transplant center and is limited to $10,000 per transplant • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need • Physician services	<u>In Network</u> $100 copayment per admission You pay nothing for physician services while inpatient at a hospital Humana Group PPO Plan requires prior authorization for inpatient services. Call 1-800-523-0023, (TTY# 711) All transplant services must receive prior authorization. Call 1-866-421-5663 (TTY# 711) Monday-Friday 8:30 a.m.-5 p.m. EST. The facility must be Medicare approved and part of the Humana Transplant Network. <u>Out of Network</u> $100 copayment per admission You pay nothing for physician services while inpatient at a hospital Humana Group PPO Plan requests prior authorization for inpatient services. Call 1-800-523-0023, (TTY# 711) All transplant services must receive prior authorization. Call 1-866-421-5663 (TTY# 711) Monday-Friday 8:30 a.m.-5 p.m. EST. The facility must be Medicare approved and part of the Humana Transplant Network.

Services that are covered for you	**What you must pay** when you get these services
• Prior authorization is required for in-network inpatient hospital care • Prior authorization is required for transplant services	
Inpatient mental health care Covered services include mental health care services that require a hospital stay. There is 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital. • Prior authorization is required for in-network inpatient hospital care	In Network $100 copayment per admission Humana Group PPO Plan requires prior authorization for inpatient mental health care services. Call 1-800-523-0023, (TTY# 711) Out of Network $100 copayment per admission Humana Group PPO Plan requests prior authorization for inpatient mental health care services. Call 1-800-523-0023, (TTY# 711)
Skilled nursing facility (SNF) care For a definition of "skilled nursing facility", see the chapter titled "Definitions of Important Words" of this booklet. Skilled nursing facilities are sometimes called "SNFs". You are covered for medically necessary days 1-100 for each benefit period*. Prior hospital stay is not required. Covered services include, but aren't limited to, the following: • Semiprivate room or a private room if medically necessary • Meals, including special diets	In-Network You pay nothing for days 1-100 Humana Group PPO Plan requires prior authorization for skilled nursing facility care services. Call 1-800-523-0023, (TTY# 711) Out-of-Network You pay nothing for days 1-100

Services that are covered for you	**What you must pay** when you get these services
• Regular nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs, including substances that are naturally present in the body, such as blood clotting factors • Blood, including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances, such as wheelchairs ordinarily provided by SNFs • Physician services Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital • Prior authorization is required for in-network inpatient skilled nursing care *A benefit period begins the day you go to a skilled nursing facility. The benefit period ends when you have not received skilled nursing care for 60 days in a row. (See the chapter titled "Definitions of Important Words" for a definition of "Benefit period".)	Humana Group PPO Plan requests prior authorization for skilled nursing facility care services. Call 1-800-523-0023, (TTY# 711)

Services that are covered for you	**What you must pay** when you get these services
Inpatient services when the psychiatric or skilled nursing facility days are no longer covered Covered services include, but aren't limited to, the following: • Physician services • Tests (X-ray or lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces,trusses, artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, occupational therapy, and speech therapy	In-Network You are covered for these services according to Medicare guidelines. You pay nothing Out-of-Network You are covered for these services according to Medicare guidelines. You pay nothing
Home health agency care Covered services include, but aren't limited to, the following: • Part-time or intermittent skilled nursing and home health aid services. (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical social services • Medical equipment and supplies	In Network You pay nothing Humana Group PPO Plan requires prior authorization for home health services. Call 1-800-523-0023,(TTY# 711) Out of Network You pay nothing

Services that are covered for you	**What you must pay** when you get these services
• Prior authorization is required for in-network home health care	Humana Group PPO Plan requests prior authorization for home health services. Call 1-800-523-0023,(TTY# 711)
Hospice care You may receive care from any Medicare-certified hospice program. Original Medicare (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. However, Original Medicare will pay for all of your Part A and Part B services. Your Provider will bill Original Medicare for these services while your hospice elections is in force. Covered services include, but aren't limited to, the following: • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Original Medicare • Home care Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	When you enroll in a Medicare-certified Hospice program, your hospice services and your Original Medicare services are paid by Original Medicare, not your Humana Medicare Employer PPO
Outpatient Services	
Physician services, including doctor's office visits Covered services include, but aren't limited to, the following:	In Network $10 copayment for each primary care physician office visit

Services that are covered for you	**What you must pay** when you get these services
• Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center • Consultation, diagnosis, and treatment by a specialist • Second opinion by another plan provider prior to surgery • Outpatient hospital services • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	$20 copayment for each specialist office visit You pay nothing for drugs administered in a physician office. <u>Out of Network</u> $10 copayment for each primary care physician office visit $20 copayment for each specialist office visit You pay nothing for drugs administered in a physician office.
Allergy serum and injections	<u>In Network</u> You pay nothing <u>Out of Network</u> You pay nothing
Chiropractic services Covered services include, but aren't limited, to the following: • Manual manipulation of the spine to correct subluxation • Routine services are limited to 20 visits per plan year	<u>In Network</u> You pay nothing for Medicare covered chiropractic services $20 copayment for each primary care physician office visit for routine services $20 copayment for each specialist office visit for routine services $20 copayment for each immediate care facility visit for routine services

Services that are covered for you	**What you must pay** when you get these services
	Out of Network You pay nothing for Medicare covered chiropractic services $20 copayment for each primary care physician office visit for routine services $20 copayment for each specialist office visit routine services $20 copayment for each immediate care facility visit routine services
Podiatry services Covered services include, but aren't limited to, the following: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs • Limited to Medicare covered services	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.
Outpatient mental health care Covered services include, but aren't limited to, the following: • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.

Services that are covered for you	**What you must pay** when you get these services
	Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.
Partial hospitalization services • "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization • Prior authorization is required for in-network partial hospitalization services	In Network You pay nothing Out of Network You pay nothing
Outpatient substance abuse services	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.
Observation	In Network $50 copayment for each outpatient hospital visit

Services that are covered for you	**What you must pay** when you get these services
	Out of Network $50 copayment for each outpatient hospital visit
~~**Outpatient surgery, including services provided at ambulatory surgical centers**~~ • Prior authorization is required for in-network abdominoplasty, blepharoplasty, breast procedures, otoplasty, elective outpatient diagnostic cardiac catheterization, penile implant, rhinoplasty, septoplasty, obesity, and oral surgeries	procedures performed in a In Network $50 copayment for ~~each~~ primary care physician office ~~visit~~ $50 copayment for ~~each~~ specialist office ~~visit~~ $50 copayment for each ambulatory surgical center visit $50 copayment for each outpatient hospital visit $50 copayment for each immediate care facility visit You pay nothing for nail debidement in all places of treatment. Out of Network $50 copayment for each primary care physician office visit $50 copayment for each specialist office visit $50 copayment for each ambulatory surgical center visit $50 copayment for each outpatient hospital visit

Outpatient surgery, and/ or Outpatient surgical procedures, including services provided at ambulatory surgical centers

procedures performed in a

Services that are covered for you	**What you must pay** when you get these services
	$50 copayment for each immediate care facility visit You pay nothing for nail debidement in all places of treatment.
Ambulance services Covered services include, but aren't limited to, the following: • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required	In Network You pay nothing Out of Network You pay nothing
Emergency care You are covered for Emergency care worldwide.	In Network $50 copayment for each emergency room visit (waived if admitted to hospital within 24 hours) Out of Network $50 copayment for each emergency room visit

Services that are covered for you	**What you must pay** when you get these services
	You do not pay the emergency room visit copayment if you are admitted to the hospital within 24 hours for the same condition, or if you are at a hospital outside of the United States. World-wide: $50 copayment for each visit. (waived if admitted to hospital within 24 hours) This benefit does not apply to your annual deductible or your annual out-of-pocket maximum
Urgently needed care You are covered for Urgently needed care worldwide.	<u>In Network</u> $10 copayment for each primary care physician office visit $20 copayment for each specialist office visit You pay nothing for each immediate care facility visit <u>Out of Network</u> $10 copayment for each primary care physician office visit $20 copayment for each specialist office visit You pay nothing for each immediate care facility visit World-wide: $50 copayment for each visit. (waived if admitted to hospital within 24 hours) This benefit does not apply to your annual deductible or your annual out-of-pocket maximum

Services that are covered for you	**What you must pay** when you get these services
Outpatient rehabilitation services Covered services include, but aren't limited to, the following: • Physical therapy • Occupational therapy • Speech language therapy • Cardiac rehabilitation services (not available at comprehensive outpatient rehabilitation facility) • Intensive cardiac rehabilitation services • Pulmonary rehabilitation services • Comprehensive Outpatient Rehabilitation Facility (CORF) services • Prior authorization is required for in-network physical, occupational, and speech therapies	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.
Medical supplies	In Network You pay nothing Out of Network You pay nothing
Durable medical equipment and related supplies For definition of "durable medical equipment" see the chapter titled "Definitions of Important Words" of this booklet. Covered services include, but aren't limited to, the following: • Wheelchairs • Crutches • Hospital beds • IV infusion pump • Oxygen equipment • Nebulizer • Walker	In Network You pay nothing Humana Group PPO Plan requires prior authorization for durable medical equipment and related supplies. Call 1-800-523-0023, (TTY # 711) Out of Network You pay nothing

Services that are covered for you	**What you must pay** when you get these services
• Prior authorization is required for in-network cochlear and auditory brainstem implants, CPAP/BiPAP, CPM machines, cranial orthotics, electric beds, electric wheelchairs and scooters, high frequency chest compression vests, pain infusion pumps, stimulator devices (including bone growth, neuromuscular, and spinal cord), and any DME item over $750	Humana Group PPO Plan requests prior authorization for durable medical equipment and related supplies. Call 1-800-523-0023, (TTY # 711)
Prosthetic devices and related supplies Devices, other than dental, that replace a body part or function. Covered services include, but aren't limited to, the following: • Colostomy bags and supplies directly related to colostomy care • Pacemakers • Braces, prosthetic shoes, and artificial limbs • Breast prostheses, including a surgical brassiere after a mastectomy • Certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices • Some coverage following cataract removal or cataract surgery. See "Vision Care" later in this section for more details • Prior authorization is required for in-network prosthetic devices	In Network You pay nothing Humana Group PPO Plan requires prior authorization for prosthetic devices and related supplies. Call 1-800-523-0023, (TTY # 711) Out of Network You pay nothing Humana Group PPO Plan requests prior authorization for prosthetic devices and related supplies. Call 1-800-523-0023, (TTY # 711)
Diabetes self-monitoring training For all people who have diabetes (insulin and non-insulin users). Covered services include, but aren't limited to, the following: • Self-management training is covered under certain conditions	In-Network You pay nothing for training if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.

Services that are covered for you	**What you must pay** when you get these services
	Benefit does not apply to your annual deductible. Out-of-Network You pay nothing for training if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefit does not apply to your annual deductible.
Diabetes self-monitoring supplies For all people who have diabetes (insulin and non-insulin users). Covered services include, but aren't limited to, the following: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • One pair per plan year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease. Coverage includes fitting • For persons at risk of diabetes, fasting plasma glucose tests are covered as often as medically necessary	In Network You pay nothing Medicare-covered diabetic monitoring supplies received from a pharmacy do not apply to your annual deductible Out of Network You pay nothing Medicare-covered diabetic monitoring supplies received from a pharmacy do not apply to your annual deductible

Services that are covered for you	**What you must pay** when you get these services
Medical nutrition therapy	
For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefit does not apply to your annual deductible Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefit does not apply to your annual deductible
Kidney Disease Education Services	
Kidney Disease Education Services - Education to teach kidney care and help members make informed decisions about their care. For people with stage IV chronic kidney disease when referred by their doctor. We cover up to six sessions of kidney disease education services per lifetime.	In Network $10 copayment for each primary care physician office visit You pay nothing for each specialist office visit You pay nothing for each outpatient hospital visit Out of Network $10 copayment for each primary care physician office visit

Services that are covered for you	**What you must pay** when you get these services
	You pay nothing for each specialist office visit You pay nothing for each outpatient hospital visit
Advanced imaging • Prior authorization is required for in-network CT scans, MRI, and MRA	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.
Nuclear medicine • Prior authorization is required for in-network PET scans, PET scan registry (NOPR), and SPECT	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic procedures and tests Covered services include, but aren't limited to, the following: • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need • Surgical supplies, such as dressings • Supplies, such as splints and casts • X-rays • Diagnostic mammography • Prior authorization is required for in-network molecular diagnostic/genetic testing	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.
Laboratory services	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.

Services that are covered for you	**What you must pay** when you get these services
Radiation therapy	
• Prior authorization is required for in-network radiation therapy	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.
Vision - Medicare-covered services only	
Covered services include, but aren't limited to, the following: • Outpatient physician services for eye care • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant	In-Network $20 copayment for each specialist office visit for Medicare covered vision services. You pay nothing for eyeglasses and contact lenses following cataract surgery Out-of-Network $20 copayment for each specialist office visit for Medicare covered vision services. You pay nothing for eyeglasses and contact lenses following cataract surgery

Services that are covered for you	**What you must pay** when you get these services
Dental - Medicare-covered services only	
Covered services include, but aren't limited to, the following: • Surgery of the jaw or related structures • Setting fractures of the jaw or facial bones • Extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease • Services that would be covered when provided by a doctor	In-Network $20 copayment for each specialist office visit for Medicare covered vision services. Out-of-Network $20 copayment for each specialist office visit for Medicare covered vision services.
Hearing - Medicare-covered services only	
Covered services include, but aren't limited to, the following: • Diagnostic hearing exams	In-Network $20 copayment for each specialist office visit for Medicare covered vision services. Out-of-Network $20 copayment for each specialist office visit for Medicare covered vision services.
Preventive Care and Screening Tests	
Abdominal aortic aneurysm screening	
A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.	In-Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.

Services that are covered for you	**What you must pay** when you get these services
	Benefits received at any place of treatment do not apply to your annual deductible Out-of-Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible
Bone mass measurements for qualified individuals that are at risk of bone loss or osteoporosis For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered once per year or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality including physician's interpretation of the results.	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service.

Services that are covered for you	**What you must pay** when you get these services
	Benefits received at any place of treatment do not apply to your annual deductible
Colorectal screening Covered services include, but aren't limited to, the following: For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) once per year • Fecal occult blood test, once per year For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) once per year	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible
Diabetes screening • One screening exam every 12 months	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible

Services that are covered for you	**What you must pay** when you get these services
	Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible
EKG Screening • One screening exam every 12 months	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible

Services that are covered for you	**What you must pay** when you get these services
HIV screening Covered services include, but aren't limited to the following: For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible
Glaucoma testing • One screening exam every 12 months	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible

Services that are covered for you		**What you must pay** when you get these services
		Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible
Immunizations Covered services include, but aren't limited to, the following: • Pneumonia vaccine • Flu shots once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk		In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible

Services that are covered for you	**What you must pay** when you get these services
Mammography screening	
Covered services include, but aren't limited to, the following: • One baseline exam between the ages of 35 and 39 • One screening per year for women age 40 and older	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible
Pap test, pelvic exam, and clinical breast exam	
Covered services include, but aren't limited to, the following: • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once per year • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test once per year	In Network $10 copayment for each primary care physician office visit $20 copayment for each specialist office visit Benefits received at any place of treatment do not apply to your annual deductible

Services that are covered for you	**What you must pay** when you get these services
	Out of Network $10 copayment for each primary care physician office visit $20 copayment for each specialist office visit Benefits received at any place of treatment do not apply to your annual deductible
Prostate cancer screening exams For men 50 and older, covered services include, but aren't limited to, the following: • Digital rectal exam once per year • Prostate Specific Antigen (PSA) test once per year	In Network $10 copayment for each primary care physician office visit $20 copayment for each specialist office visit Benefits received at any place of treatment do not apply to your annual deductible Out of Network $10 copayment for each primary care physician office visit $20 copayment for each specialist office visit Benefits received at any place of treatment do not apply to your annual deductible

Services that are covered for you	**What you must pay** when you get these services
Cardiovascular disease testing Covered services include, but aren't limited to, the following: Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) Covered as frequently as medically necessary	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible
Physical exams You are covered for one routine physical per year. Covered services include, but aren't limited to, the following: • Counseling on diet, exercise, substance abuse, and injury prevention • Height and weight measurement at intervals according to provider's clinical discretion • Blood pressure • Vision screening at provider's discretion	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible

Services that are covered for you	**What you must pay** when you get these services
	Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible
Smoking cessation Medicare - covered services only	In Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible Out of Network You pay nothing if these are the only services being rendered. If other services are rendered in addition to these services, your cost will depend on the place of service. Benefits received at any place of treatment do not apply to your annual deductible

Services that are covered for you	**What you must pay** when you get these services
Other Services	
Renal (Kidney) dialysis Covered services include, but aren't limited to, the following: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies. See "Durable medical equipment and related supplies" for details • Certain home support services (such as when medically necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply.) See "Home health agency care" for details	In Network You pay nothing Out of Network You pay nothing
Chemotherapy drugs	In Network You pay nothing Out of Network You pay nothing
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services	In Network You pay nothing for Medicare Part B drugs You pay nothing for administration of drugs in a physician's office

Services that are covered for you	**What you must pay** when you get these services
• Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen(R), Procrit(R), Epoetin Alfa, Aranesp(R), or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Prior authorization may be required for Part B drugs. Contact plan for details	Out of Network You pay nothing for Medicare Part B drugs You pay nothing for administration of drugs in a physician's office
Additional Benefits	
Acupuncture • Limited to 20 visits per plan year	In Network You pay nothing Out of Network You pay nothing

Services that are covered for you		**What you must pay** when you get these services
Massage Therapy		
• Limited to 20 visits per plan year		In Network You pay nothing Out of Network You pay nothing

PEIA Retiree Assistance Program

The PEIA retiree assistance program offers retirees the opportunity for decreased premiums as well as modifications to their benefits. If PEIA determines you qualify for this assistance, please refer to the chart below for your modified benefit information. For more information regarding qualifications, please contact PEIA.

Medical

- $300 Maximum out-of-pocket.
- $25 Deductible
- $2 co-payment for each Primary Care Physician office visit.
- $5 co-payment for each Specialist office visit.

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs	
HumanaFirst (R) 24 Hour Nurse Advice Line As a Humana member, you have access to health information, guidance, and support. Whether you have an immediate health concern or questions about a particular medical condition, call HumanaFirst for expert advice and guidance at no additional cost to you. Just call 1-800-622-9529, TTY 1-888-791-2008 to talk to a nurse. Why call HumanaFirst? You may not have health concerns or medical questions very often but when you do, call the HumanaFirst Nurse Advice Line. We're your health information and support team: • If you need a refresher course in changing your bandage after a recent surgery • If you've been diagnosed with a medical condition such as diabetes or cancer • If you have a fever at 3:00 a.m. in the morning	HumanaFirst (R) 24 Hour Nurse Advice Line is available in all states.
Well Dine Inpatient Meal Program After your overnight stay in the hospital or nursing facility, you are eligible for ten nutritious, pre-cooked, frozen meals delivered to your door at no cost to you. To arrange for this service, simply call 1-866-96MEALS (1-866-966-3257) after your discharge and provide your Humana member ID number, and other basic information. A Humana representative will assist you in scheduling your delivery.	The Well Dine program is available in all states except Alaska and Hawaii.

Services that are covered for you	**What you must pay** when you get these services
SilverSneakers (R) Fitness Program You are covered for membership to a participating SilverSneakers (R) fitness program. Your benefits include: • A basic fitness center membership at a participating location near you with access to the basic amenities • Custom designed, low impact classes designed to improve your body's strength and flexibility • On-site advisors to act as your contact for information and personalized service • Social events • Self directed SilverSneakers (R) Steps program with focus on improving strength and mobility, available to members that are not located within a 15-mile radius of a fitness center	The SilverSneakers (R) Fitness Program is available in all states except Arizona, Pennsylvania, and Nevada.
Silver & Fit(TM) Fitness Program You are covered for membership to a participating fitness club. Your benefits include: • A basic fitness center membership at a participating location near you with access to the basic amenities • Custom designed, low impact classes designed to improve your body's strength and flexibility • Social events	The Silver & Fit(TM) Fitness Program is available only in Arizona, Pennsylvania, and Nevada.
QuitNet (R) smoking cessation program Comprehensive smoking cessation services include: • Web based or telephonic counseling/coaching • QuitGuide, and QuitTips e-mail support • Over-the-counter nicotine replacement therapy which includes; Nicoderm (R) Patch, Nicorette (R) Gum and Commit (R) Lozenge products You can enroll by phone at 1-888-572-4074 (TTY: 711), 8 a.m. to 12 a.m., Monday through Friday, or 8:30 a.m. to 5 p.m., Saturday, Eastern Standard time. Or enroll online at quitnet.com/humana.	The QuitNet (R) smoking cessation program is available in all states.

Services that are covered for you	**What you must pay** when you get these services
Humana Active Outlook (R) Medicare members benefit from exclusive lifestyle enrichment through our award-winning program. Medicare members get the following benefits of Humana Active Outlook at no additional cost. **Humana Active Outlook printed resources** • ***HAO* Magazine**, our quarterly award-winning publication with inspiring stories for active, fun, healthy living • ***Live It Up!* Digest**, a quarterly publication to help members with chronic conditions manage their health **Humana Active Outlook Website** **HumanaActiveOutlook .com**, your Web source for custom health and wellness information and interactive tools. **Humana Active Outlook Classes and Seminars** Learn more about how you can live a healthier lifestyle! Join other members to learn about brain fitness, the right way to exercise, how to eat healthy, computers and technology, managing conditions, and understanding your healthcare experience in our local health and wellness classes in select communities. And don't miss out on our health education seminars, where you'll learn about condition-specific topics such as diabetes or osteoporosis. Watch presentations from experts, get a health screening, hear the latest information on health conditions, and talk with professionals who can answer your questions. ***Heal!*** Personalized Health Programs Condition-specific information on managing diabetes, cardiovascular health, cancer, COPD, weight, chronic conditions, and back health care. **Life Works** Member Assistance Program	Humana Active Outlook (R) (HAO) Magazine is available in all states.

Getting care using our plan's traveler benefit

You may get care when you are outside the service area. You may need to pay higher cost sharing for routine care from non-network providers, but you won't pay extra in a medical emergency or if your care is urgently needed. If you have questions about your medical costs when you travel, please call Customer Care Team.

SECTION 3 What types of benefits are not covered by the plan?

Types of benefits we do *not* cover (exclusions)

This section tells you what kinds of benefits are "excluded." Excluded means that the plan doesn't cover these benefits.

The list below describes some services and items that aren't covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to the chapter titled "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren't covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as a covered services

- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study. See Chapter 3, Section 5 for more information on clinical research studies

- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare

- Private room in a hospital, except when it is considered medically necessary

- Private duty nurses
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television
- Full-time nursing care in your home
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation
- Fees charged by your immediate relatives or members of your household
- Meals delivered to your home except those included in the Well Dine benefit
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- Cosmetic surgery or procedures because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
- Routine dental care, such as cleanings, filings, or dentures. However, non-routine dental care received at a hospital may be covered
- Routine foot care, except for the limited coverage provided according to Medicare guidelines
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- Hearing aids and routine hearing examinations

- Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery

- Outpatient prescription drugs including drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy. *Please see your drug benefits for possible coverage details.*

- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies

- Naturopath services (uses natural or alternative treatments)

- Any services listed above that aren't covered will remain not covered even if received at an emergency facility

Chapter 5. Asking the plan to pay its share of a bill you have received for covered services

SECTION 1 Situations in which you should ask our plan to pay our share of the cost of your covered services

If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. **When you've received medical care from a provider who is not in our plan's network**

   When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. (Your share of the cost may be higher for an out-of-network provider than for a contracted provider.) You should ask the provider to bill the plan for our share of the cost.

   - If you paid the entire amount yourself at the time you received the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.

   - At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.

     - If the provider is owed anything, we will pay the provider directly.

     - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

- **Please note:** While you can get your care from an out-of-network provider, the provider must participate in Medicare. We cannot pay a provider who has decided not to participate in Medicare. You will be responsible for the full cost of the services you receive.

2. **When a contracted provider sends you a bill you think you should not pay**

Contracted providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- Whenever you get a bill from a contracted provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.

- If you have already paid a bill to a contracted provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

Mail your request for payment together with any bills or receipts to us at this address:

Humana Claims Office
PO Box 14601
Lexington, KY 40512-4601

Please be sure to contact the Customer Care Team if you have any questions. If you don't know what you owe, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and decide whether to pay it and how much we owe.

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services.)

- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

If we tell you that we will not pay for the medical care, you can make an appeal

If you think we have made a mistake in turning you down your request for payment, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a legal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 7 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5 in Chapter 7.

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, in large print, or other alternate formats, etc.)

We must treat you with fairness and respect at all times

We must ensure that you get timely access to your covered services

We must protect the privacy of your personal health information

We must give you information about the plan, its network of providers, and your covered services

We must support your right to make decisions about your care

You have the right to make complaints and to ask us to reconsider decisions we have made

What can you do if you think you are being treated unfairly or your rights are not being respected?

How to get more information about your rights

SECTION 2 You have some responsibilities as a member of the plan

What are your responsibilities?

SECTION 1 Our plan must honor your rights as a member of the plan

We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call the Customer Care Team (phone numbers are on the back of your membership card).

Our plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please the Customer Care Team (phone numbers are on the back of your membership card). If you have a complaint, such as a problem with wheelchair access, the Customer Care Team can help.

We must ensure that you get timely access to your covered services

As a member of our plan, you have the right to choose a provider in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call the Customer Care Team to learn which doctors are accepting new patients (phone numbers are on the back of your membership card). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

You have the right to choose a provider in the plan's network. Call the Customer Care Team to learn which doctors are accepting new patients (phone numbers are on the back of your membership card). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

As a plan member, you have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 of this booklet tells what you can do.

We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice", that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.

- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

    - For example, we are required to release health information to government agencies that are checking on quality of care.

    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call the Customer Care Team (phone numbers are on the back of your membership card).

Notice of Privacy Practices for your personal health information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You don't need to do anything unless you have a request or complaint.

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information. We follow the privacy practices described in this notice and will notify you of any changes.

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a health

care provider or health plan that relates to your physical or mental health or condition, providing health care to you, or the payment for such health care.

How does Humana protect my information?

In keeping with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy policies and procedures

How does Humana use and disclose my information?

We must use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law.

We have the right to use and disclose your information:

- To a doctor, a hospital, or other health care provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by health care providers and for health plan premium payments
- For health care operation activities, including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of health care professionals, and determining premiums
- For performing underwriting activities
- To your plan sponsor to permit them to perform plan administration functions
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you
- To your family and friends if you are unavailable to communicate, such as in an emergency
- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence

- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law
- To assist in disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill Humana's obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- For procurement, banking, or transplantation of organs, eyes, or tissue
- To a coroner, medical examiner, or funeral director.

Will Humana use my information for purposes not described in this notice?

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

What does Humana do with my information when I am no longer a Humana member or I do not obtain coverage through Humana?

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through Humana. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

The following are your rights with respect to your information:

- Access - You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- Alternate Communications - You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life-threatening situation. We will accommodate your request if it is reasonable.
- Amendment - You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.

- Disclosure - You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. Effective April 1, 2003, or whenever you became a Humana member, Humana began maintaining these types of disclosures and will maintain this information for a period of six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Notice - You have the right to receive a written copy of this notice any time you request.
- Restriction - You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at Humana.com and going to the Privacy Practices link
- E-mailing us at privacyoffice@humana.com

Send completed request form to:
Humana Privacy Office
P.O. Box 1438
Louisville, KY 40202

What should I do if I believe my privacy has been violated?

If you believe your privacy has been violated in any way, you may file a complaint with Humana by calling us at: 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to OCRComplaint@hhs.gov. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

Humana follows all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, Humana follows the law, rule, or regulation which provides greater member protection.

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

American Dental Plan of North Carolina, Inc.
American Dental Providers of Arkansas, Inc.
CarePlus Health Plans, Inc.
Cariten Insurance Company
Cariten Health Plan
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
CorpHealth, Inc
Corphealth Provider Link, Inc.
DentiCare, Inc.
Emphesys Insurance Company
Emphesys, Inc.
HumanaDental Insurance Company
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Benefit Plan of Illinois, Inc.
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Medical Plan of Utah, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Managed Care Indemnity, Inc.
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

We must give you information about the plan, its network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call the Customer Care Team (phone numbers are on the back of your membership card):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.

- **Information about our contracted providers.**

    - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.

    - For a list of the providers in the plan's network, see the Provider Directory.

    - For more detailed information about our providers, you can call the Customer Care Team (phone numbers are on the back of your membership card) or visit our website at Humana.com.

- **Information about your coverage and rules you must follow in using your coverage.**

    - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.

    - If you have questions about the rules or restrictions, please call the Customer Care Team (phone numbers are on the back of your membership card).

- **Information about why something is not covered and what you can do about it.**

    - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.

- If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

- If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 7 of this booklet.

We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives** ." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.
If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital** .

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with state agency that handles advance directives.

You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do ask for a coverage decision, make an appeal, or make a complaint **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call the Customer Care Team (phone numbers are on the back of your membership card).

What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call the Customer Care Team** (phone numbers are on the back of your membership card).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.

How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call the Customer Care Team** (phone numbers are on the back of your membership card).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare** .
    - You can visit the Medicare website (http:// www.medicare.gov) _ to read or download the publication "Your Medicare Rights & Protections."
    - Or, you can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call the Customer Care Team (phone numbers are on the back of your membership card). We're here to help.

- ***Get familiar with your covered services and the rules you must follow to get these covered services.*** *Use this* Evidence of Coverage *booklet to learn what is covered for you and the rules you need to follow to get your covered services.*
    - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.

- ***If you have any other health insurance coverage besides our plan, you are required to tell us.*** *Please call the Customer Care Team to let us know.*

    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other health benefits available to you. We'll help you with it.

- ***Tell your doctor and other health care providers that you are enrolled in our plan.*** *Show your plan membership card whenever you get your medical care.*

- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***

    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.

    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- ***Be considerate.*** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*

- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*

    - If you have a monthly plan premium, you must pay your plan premiums to continue being a member of our plan.

    - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.

    - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call the Customer Care Team (phone numbers are on the back of your membership card).*

    - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.

    - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.

- ***Call the Customer Care Team for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*

    - Phone numbers and calling hours for the Customer Care Team are on the back of your membership card.

For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

SECTION 1 Introduction

What to do if you have a problem or concern

What about the legal terms?

SECTION 2 You can get help from government organizations that are not connected with us

Where to get more information and personalized assistance

SECTION 3 To deal with your problem, which process should you use?

Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Asking for coverage decisions and making appeals: the big picture

How to get help when you are asking for a coverage decision or making an appeal

Which section of this chapter gives the details for your situation?

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Step-by-step: How to make a Level 2 Appeal

What if you are asking our plan to pay you for our share of a bill you have received for medical care?

SECTION 6 How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon

During your hospital stay, you will get a written notice from Medicare that tells about your rights

Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

What if you miss the deadline for making your Level 1 Appeal?

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

This section is about three services <u>only:</u> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

We will tell you in advance when your coverage will be ending

MAKING COMPLAINTS

BACKGROUND

SECTION 1 Introduction

What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call Customer Care Team (contact information is on the back of your membership card). We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.

This chapter explains two types of formal processes for handling problems:

- For some types of problems, you need to use the **process for coverage decisions and making appeals**.
- For other types of problems you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using more common words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful - and sometimes quite important - for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. Perhaps both are true for you.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program**. This government program has trained counselors in every state. The program is not connected with our plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

Their services are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (http://www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern and you want to do something about it, you don't need to read this whole chapter. You just need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter tells what to do for your problem or concern, **START HERE**

Is your problem or concern about your benefits and coverage? (This includes problems about whether particular medical care is covered or not, the way in which they are covered, and problems related to payment for medical care.)	
YES	**NO**
Go on to the next section of Section 4: "A guide to the basics of coverage decisions and making appeals."	Skip ahead to Section 9 at the end of this chapter: "How to make a complaint about quality of care, waiting times, Customer Care Team or other concerns."

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. We make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the service is covered and pay our share of the cost.
- But in some cases we might decide the service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Care Team** (contact information is on the back of your membership card).

- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).

- **You should consider getting your doctor or other provider involved if possible, especially if you want a "fast" or "expedited" decision.** In most situations involving a coverage decision or appeal, your doctor or other provider must explain the medical reasons that support your request. Your doctor or other prescriber can't request every appeal. He/she can request a coverage decision and a Level 1 Appeal with the plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your "representative" (see below about "representatives").

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.

    - There may be someone who is already legally authorized to act as your representative under State law.

    - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Care Team and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Which section of this chapter gives the details for <u>your</u> situation?

There are three different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

Section 5 of this chapter	**Section 6** of this chapter	**Section 7** of this chapter
"Your medical care: How to ask for a coverage decision or make an appeal"	"How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon"	"How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're still not sure which section you should be using, please call Customer Care Team (contact information is on the back of your membership card). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

? Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These are the benefits described in Chapter 4 of this booklet: *Medical benefits chart (what is covered and what you pay*). To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.

3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.

4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.

5. You are being told that coverage for certain medical care you have been getting will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

    - NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- Chapter 7, Section 6: *How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.*

- Chapter 7, Section 7: *How to ask our plan to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?		
Do you want to find out whether our plan will cover the medical care or services you want?	Has our plan already told your that we will <u>not</u> cover or pay for a medical services in the way you want it to be covered or paid for?	Do you want to ask our plan to pay you back for medical care or services you have already received and paid for?
You need to ask our plan to make a coverage decision for you. (see Section 5 of this Chapter)	You can make an **appeal**. (This means you are asking us to reconsider.) (see Section 5 of this Chapter)	You can send us the bill. (see Section 5 of this Chapter)

Step-by-step: How to ask for a coverage decision
(how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms	A coverage decision is often called an **"initial determination"** or "initial decision." When a coverage decision involves your medical care, the initial determination is called an **"organization determination ."**

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast decision."

Legal Terms	A "fast decision" is called an **"expedited decision."**

How to request coverage for the medical care you want

- Start by writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.

- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care*.

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.

- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

If your health requires it, ask us to give you a "fast decision"

- **A fast decision means we will answer within 72 hours.**

    - **However, we can take up to 14 more days** if we find that some information is missing that may benefit you, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.

- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.

- **To get a fast decision, you must meet two requirements:**

  - You can get a fast decision only if you are asking for coverage for medical care *you have not yet received* . (You cannot get a fast decision if your request is about payment for medical care you have already received.)

  - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

- **If your doctor tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**

- If you ask for a fast decision on your own, without your doctor's support, our plan will decide whether your health requires that we give you a fast decision.

  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).

  - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.

  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

<u>Step 2:</u> Our plan considers your request for medical care coverage and we give you our answer.

*Deadlines for a **"fast"** coverage decision*

- Generally, for a fast decision, we will give you our answer **within 72 hours**.

- As explained above, we can take up to 14 more days under certain circumstances. If we take extra days, it is called "an extended time period."

- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Step 3 below tells how to make an appeal.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

*Deadlines for a **"standard"** coverage decision*

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request.**

  - We can take up to 14 more days ("an extended time period") under certain circumstances.

  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Step 3 below tells how to make an appeal.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

<u>Step 3:</u> If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If our plan says no, you have the right to ask us to reconsider - and perhaps change - this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.

- If you decide to make appeal, it means you are going on to Level 1 of the appeals process (see Steps 1-3 listed below).

Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms	When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal." An appeal to the plan about a medical care coverage decision is called a plan "**reconsideration** ."

Step 1: You contact our plan and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start an appeal you, your representative, or in some cases your doctor must contact our plan.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, *How to contact our plan when you are making an appeal about your medical care.*

- **Make your standard appeal in writing by submitting a signed request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact our plan when you are making an appeal about your medical care*).

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.

- **You can ask for a copy of the information in your appeal and add more information if you like.**

  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make an oral request)

Legal Terms	A "fast appeal" is also called an **"expedited appeal."**

- If you are appealing a decision our plan made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."

- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast decision." To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)

Step 2: Our plan considers your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were being fair and following all the rules when we said no to your request.

- We will gather more information if we need it. We may contact you or your doctor to get more information.

*Deadlines for a **"fast" appeal***

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.

    - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more days.**

    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours.

- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have sent your appeal to the Independent Review Organization for a Level 2 Appeal.

*Deadlines for a **"standard" appeal***

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.

    - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more days.**

    - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.

- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have sent your appeal to the Independent Review Organization for a Level 2 Appeal.

<u>Step 3:</u> If our plan says no to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were being fair when we said no to your appeal, **our plan is required to send your appeal to the "Independent Review Organization ."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Step-by-step: How to make a Level 2 Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**

- You have a right to give the Independent Review Organization additional information to support your appeal.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

*If you had a "fast" appeal at Level 1, you will also have a **"fast" appeal** at Level 2*

- If you had a fast appeal to our plan at Level 1 and requested a fast appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more days**.

*If you had a "standard" appeal at Level 1, you will also have a **"standard" appeal** at Level 2*

- If you made a standard appeal to our plan at Level 1 and requested a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.

- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more days**.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 days after we receive the decision from the review organization.

- **If this organization says no to your appeal**, it means they agree with our plan that your request for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")

    - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.

- The Level 3 Appeal is handled by an administrative law judge. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

What if you are asking our plan to pay you for our share of a bill you have received for medical care?

If you want to ask our plan for payment for medical care, start by reading Chapter 5 of this booklet: *Asking the plan to pay its share of a bill you have received for medical services* . Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from our plan

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical benefits chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)

- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5 of this Chapter . Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)

- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about the plan's coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical benefits chart (what is covered and what you pay)*.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**." Our plan's coverage of your hospital stay ends on this date.

- When your discharge date has been decided, your doctor or the hospital staff will let you know.

- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

During your hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital is supposed to give it to you within two days after you are admitted.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:

    - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.

    - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.

    - Where to report any concerns you have about quality of your hospital care.

    - What to do if you think you are being discharged from the hospital too soon.

Legal Terms	The written notice from Medicare tells you how you can **"make an appeal."** Making an appeal is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time. (The steps listed below tell how to make this appeal.)

2. **You must sign the written notice to show that you received it and understand your rights.**

    - You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)

    - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

    - If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.

    - To look at a copy of this notice in advance, you can call Customer Care Team or 1-800 MEDICARE(1-800-633-4227 or TTY: 1-877-486-2048). You can also see it online at http://www.cms.hhs.gov.

Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your hospital services to be covered by our plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Care Team (contact information is on the back of your membership card). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Legal Terms	When you start the appeal process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

<u>Step 1:</u> Contact the Quality Improvement Organization in your state and ask for a "fast review" of your hospital discharge. You must act quickly.

Legal Terms	A "fast review" is also called an **"immediate review"** or an **"expedited review."**

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
    - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
    - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our plan has given to them.

- During this review process, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our plan think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms	This written explanation is called the "**Detailed Notice of Discharge."** You can get a sample of this notice by calling Customer Care Team or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can get see a sample notice online at http://www.cms.hhs.gov/BNI/

<u>Step 3:</u> Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **our plan must keep providing your covered hospital services for as long as these services are medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. (Saying *no* to your appeal is also called *turning down* your appeal.) If this happens, **our plan's coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

- If you decide to stay in the hospital, then you may **have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

<u>Step 4:</u> If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Here are the steps for Level 2 of the appeal process:

<u>Step 1:</u> You contact the Quality Improvement Organization again and ask for another review

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

<u>Step 2:</u> The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

<u>Step 3:</u> Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **Our plan must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **Our plan must continue providing coverage** for your hospital care for as long as it is medically necessary.

- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. This is called "upholding the decision." It is also called "turning down your appeal."

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

<u>Step 4:</u> If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 6, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited" review** (or **"expedited appeal"**).

<u>Step 1:</u> Contact our plan and ask for a "fast review."

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care*.

- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

<u>Step 2:</u> Our plan does a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, our plan takes a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.

- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: Our plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If our plan says yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If our plan says no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.

- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date. You will be responsible for the cost of care starting from noon on the day after our plan says no to your appeal.

Step 4: If our plan says *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were being fair when we said no to your fast appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.

- **If this organization says *yes* to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with our plan that your planned hospital discharge date was medically appropriate. (This is called "upholding the decision." It is also called "turning down your appeal.")

    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.

- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

This section is about three services only:
Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.

- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, *Definitions of important words*.)

- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical benefits chart (what is covered and what you pay)*.

When our plan decides it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *our plan will stop paying its share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask.

We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.

    - The written notice tells you the date when our plan will stop covering the care for you.

Legal Terms	In this written notice, we are telling you about a **"coverage decision"** we have made about when to stop covering your care. (For more information about coverage decisions, see Section 4 in this chapter.)

    - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms	In telling what you can do, the written notice is telling how you can **"make an appeal."** Making an appeal is a formal, legal way to ask our plan to change the coverage decision we have made about when to stop your care. (The steps listed below tell how you can make an appeal.)

Legal Terms	The written notice is called the "**Notice of Medicare Non-Coverage."** To get a sample copy, call Customer Care Team or 1-800-MEDICARE(1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at http://www.cms.hhs.gov/BNI/

2. **You must sign the written notice to show that you received it.**

    - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)

    - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)

- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Care Team (contact information is on the back of your membership card). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Legal Terms	When you start the appeal process by making an appeal, it is called the "first level of appeal" or "Level 1 Appeal."

<u>Step 1:</u> Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for our plan to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care*.

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.

- During this review process, you will also get a written notice from the plan that gives our reasons for wanting to end the plan's coverage for your services.

Legal Terms	This notice explanation is called the "**Detailed Explanation of Non-Coverage.**"

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **our plan must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** Our plan will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal - and you choose to continue getting care after your coverage for the care has ended - then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Here are the steps for Level 2 of the appeal process:

<u>Step 1:</u> You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

<u>Step 2:</u> The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

<u>Step 3:</u> Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **Our plan must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **Our plan must continue providing coverage** for the care for as long as it is medically necessary.

- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

<u>Step 4:</u> If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 7, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited" review** (or **"expedited appeal"**).

<u>Step 1:</u> Contact our plan and ask for a "fast review."

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care*.

- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

<u>Step 2:</u> Our plan does a "fast" review of the decision we made about when to stop coverage for your services.

- During this review, our plan takes another look at all of the information about your case. We check to see if we were being fair and following all the rules when we set the date for ending the plan's coverage for services you were receiving.

- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

<u>Step 3:</u> Our plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If our plan says yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If our plan says no to your fast appeal,** then your coverage will end on the date we have told you and our plan will not pay after this date. Our plan will stop paying its share of the costs of this care.

- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would your coverage ends, then **you will have to pay the full cost** of this care yourself.

<u>Step 4:</u> If our plan says *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were being fair when we said no to your fast appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

<u>Step 1:</u> We will automatically forward your case to the Independent Review Organization .

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

<u>Step 2:</u> The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

- **If this organization says *yes* to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")

    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	A judge who works for the Federal government **will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."**

- **If the answer is yes, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.

    - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge's decision.

    - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- **If the answer is no, the appeals process *may* or *may not* be over**.

    - If you decide to accept this decision that turns down your appeal, the appeals process is over.

    - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The Medicare Appeals Council **will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.**

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.

- If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.

- If we decide to appeal the decision, we will let you know in writing.

- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over.**

  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process.

- This is the last step of the administrative appeals process.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, Customer Care Team, or other concerns

? If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the Customer Care Team you receive. Here are examples of the kinds of problems handled by the complaint process.

IF YOU HAVE ANY OF THESE KIND OF PROBLEMS, YOU CAN "MAKE A COMPLAINT"

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you threat you feel should be confidential?

Disrespect, poor Customer Care Team, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Customer Care Team has dealt with you?
- Do you feel you are being encouraged to leave our plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get in?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Customer Care Team or other staff at our plan?
- Examples include waiting too long on the phone, in the waiting room, in the exam room, or when getting a prescription.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from our plan

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

POSSIBLE COMPLAINTS (CONTINUED)

These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in Sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint.

- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.

- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.

- When our plan does not give you a decision on time, we are required to forward you case to the Independent Review Organization. If we doe not do that within the required deadline, you can make a complaint.

The formal name for "making a complaint" is "filing a grievance"

Legal Terms	• What this section calls a **"complaint"** is also called a **"grievance."** • Another term for **"making a complaint"** is **"filing a grievance."** • Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Step-by-step: Making a complaint

Step 1: Contact us promptly - either by phone or in writing.

- **Usually, calling Customer Care Team is the first step.** If there is anything else you need to do, Customer Care Team will let you know.

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you do this, it means that we will use our *formal procedure* for answering grievances. Here's how it works:

  Grievance process

  You or your representative may file your concerns in writing or verbally.

  Please follow the grievance process described below:

  When filing a grievance, please provide the following information:

  Your name, address, telephone number, and member identification number; you or your authorized representative's signature and the date signed; a summary of the grievance and any previous contact with us; and a description of the action you are requesting. If you or your authorized representative require assistance in preparing and submitting your written grievance, contact our Customer Care Team at the number shown in Chapter 2 of this booklet.

  You may request an expedited (fast) grievance if:

  - You disagree with our decision to extend the timeframe to make an initial (standard) organization/coverage determination or reconsideration.

  - We deny your request for a 72-hour/fast (expedited) organization/coverage determination or reconsiderations/redeterminations.

  - We deny your request for a 72-hour/fast (expedited) appeal.

  If you mail the request for an expedited grievance, we will provide oral acknowledgement upon receipt. We will make a determination within 24 hours of receipt of your request.

- **Whether you call or write, you should contact Customer Care Team right away.** The complaint must be made within 60 days after you had the problem you want to complain about.

- **If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

Legal Terms	What this section calls a **"fast complaint"** is also called a **"fast grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 30 days, but we may take up to 44 days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan). To find the name, address, and phone number of the Quality Improvement Organization in your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work together with them to resolve your complaint.

- **Or, you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

Chapter 8. Ending your membership in the plan

SECTION 1 Ending your Membership

This chapter focuses on ending your membership in our plan

Voluntarily ending your membership

Until your membership ends, you must keep getting your Medicare services through our Plan or you will have to pay for them yourself.

We cannot ask you to leave the Plan because of your health

Involuntarily ending you membership

You have the right to make a complaint if we end your membership in our Plan

SECTION 1 Ending your Membership

This chapter focuses on ending your membership in our plan

Ending your membership in our Plan may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our Plan because you have decided that you want to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

Please be advised, you may not be able to resume group coverage from your employer or group if you voluntarily choose to disenroll from this plan. Contact the Customer Care Team or your benefit administrator before you disenroll.

Until your membership ends, you must keep getting your Medicare services through our Plan or you will have to pay for them yourself.

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect.

While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through our Plan.

If you must receive services outside of your Plan's limitations, neither we nor the Medicare program will pay for these services, with just a few exceptions. If you have any questions, please call the Customer Care Team at the number listed on the back of your membership card.

If you happen to be hospitalized on the day your membership ends, please call the Customer Care Team to find out if your hospital care will be covered by our Plan. If you have any questions about leaving our Plan, please call the Customer Care Team at the number listed on the back of your membership card.

We cannot ask you to leave the Plan because of your health.

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan:

- If you move out of the service area or are away from the service area for more than 6 months in a row. If you plan to move or take a long trip, please call the Customer Care Team to find out if the place you are moving to or traveling to is in our Plan's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row you cannot remain a member of the Plan. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you).
- If you do not stay continuously enrolled in "Medicare A and B".
- If you give us information on your enrollment request that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.

You have the right to make a complaint if we end your membership in our Plan

If we end your membership in our Plan, we will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

Chapter 9. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice of coordination of benefits

Why do we need to know if you have other coverage?

We coordinate benefits in accordance with the Medicare Secondary Payer rules, which allow us to bill, or authorize a provider of services to bill, other insurance carriers, plans, policies, employers, or other entities when the other payer is responsible for payment of services provided to you. We are also authorized to charge or bill you for amounts the other payer has already paid to you for such services. We shall have all the rights accorded to the Medicare Program under the Medicare Secondary Payer rules.

Who pays first when you have other coverage?

When you have additional coverage, how we coordinate your coverage depends on your situation. With coordination of benefits, you will often get your care as usual through our plan providers, and the other plan or plans you have will simply help pay for the care you receive. If you have group health coverage, you may be able to maximize the benefits available to you if you use providers who participate in your group plan and our plan. In other situations, such as for benefits that are not covered by our plan, you may get your care outside of our plan.

Employer and employee organization group health plans

Sometimes, a group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You have coverage under a group health plan (including both employer and employee organization plans), either directly or through your spouse, and
- The employer has twenty (20) or more employees (as determined by Medicare rules), and
- You are not covered by Medicare due to disability or End Stage Renal Disease (ESRD).

If the employer has fewer than twenty (20) employees, generally we will provide your primary health benefits. If you have retiree coverage under a group health plan, either directly or through your spouse, generally we will provide primary health benefits. Special rules apply if you have or develop ESRD.

Employer and employee organization group health plans for people who are disabled

If you have coverage under a group health plan, and you have Medicare because you are disabled, generally we will provide your primary health benefits. This happens if:

- You are under age 65, and
- You do not have ESRD, and
- You do not have coverage directly or through your spouse under a large group health plan.

A large group health plan is a health plan offered by an employer with 100 or more employees, or by an employer who is part of a multiple-employer plan where any employer participating in the plan has 100 or more employees. If you have coverage under a large group health plan, either directly or through your spouse, your large group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You do not have ESRD, and
- Are under age 65 and have Medicare based on a disability.

In such cases, we will provide only those benefits not covered by your large employer group plan. Special rules apply if you have or develop ESRD.

Employer and employee organization group health plans for people with End Stage Renal Disease ("ESRD")

If you are or become eligible for Medicare because of ESRD and have coverage under an employer or employee organization group health plan, either directly or through your spouse, your group health plan is responsible for providing primary health benefits to you for the first thirty (30) months after you become eligible for Medicare due to your ESRD. We will provide secondary coverage to you during this time, and we will provide primary coverage to you thereafter. If you are already on Medicare because of age or disability when you develop ESRD, we will provide primary coverage.

Workers Compensation and similar programs

If you have suffered a job-related illness or injury and workers compensation benefits are available to you, workers compensation must provide its benefits first for any healthcare costs related to your job-related illness or injury before we will provide any benefits under this Evidence of Coverage for services rendered in connection with your job-related illness or injury.

Accidents and injuries

The Medicare Secondary Payer rules apply if you have been in an accident or suffered an injury. If benefits under "Med Pay," no-fault, automobile, accident, or liability coverage (including, but not limited to, the government of Puerto Rico compulsory automobile insurance, known as ACAA) are available to you, the "Med Pay," no-fault, automobile, accident, or liability coverage carrier must provide its benefits first for any healthcare costs related to the accident or injury before we will provide any benefits for services related to your accident or injury.

Liability insurance claims are often not settled promptly. We may make conditional payments while the liability claim is pending. We may also receive a claim and not know that a liability or other claim is pending. In these situations, our payments are conditional. Conditional payments must be refunded to us upon receipt of the insurance or liability payment.

If you recover from a third party for medical expenses, we are entitled to recovery of payments we have made without regard to any settlement agreement stipulations. Stipulations that the settlement does not include damages for medical expenses will be disregarded. We will recognize allocations of liability payments to non-medical losses only when payment is based on a court order on the merits of the case. Humana will not seek recovery from any portion of an award that is appropriately designated by the court as payment for losses other than medical services (e.g., property losses).

Where we provide benefits in the form of services, we shall be entitled to reimbursement on the basis of the reasonable value of the benefits provided.

Non-duplication of benefits

We will not duplicate any benefits or payments you receive under any automobile, accident, liability, or other coverage. You agree to notify us when such coverage is available to you, and it is your responsibility to take any actions necessary to receive benefits or payments under such automobile, accident, liability, or other coverage. We may seek reimbursement of the reasonable value of any benefits we have provided in the event that we have duplicated benefits to which you are entitled under such coverage. You are obligated to cooperate with us in obtaining payment from any automobile, accident, or liability coverage or other carrier.

If we do provide benefits to you before any other type of health coverage you may have, we may seek recovery of those benefits in accordance with the Medicare Secondary Payer rules. Please also refer to the Subrogation and third-party recovery section for more information on our recovery rights.

More information

This is just a brief summary. Whether we pay first or second - or at all - depends on what types of additional insurance you have and the Medicare rules that apply to your situation. For more information, consult the brochure published by the government called "Medicare and Other Health Benefits: Your Guide to WHO PAYS FIRST."It is CMS Pub. No. 02179. Be sure to consult the most current version. Other details are explained in the Medicare Secondary Payer rules, such as the way the number of persons employed by an employer for purposes of the coordination of benefits rules is to be determined. The rules are published in the Code of Federal Regulations.

Appeal rights

If you disagree with any decision or action by our plan in connection with the coordination of benefits and payment rules outlined above, you must follow the procedures explained in Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) in this Evidence of Coverage.

SECTION 4 Notice of subrogation and third-party recovery

Subrogation

If we make any payment to you or on your behalf for covered services, we are entitled to be fully subrogated to any and all rights you have against any person, entity, or insurer that may be responsible for payment of medical expenses and/or benefits related to your injury, illness, or condition. We are entitled to exercise the same rights of subrogation and recovery that are accorded to the Medicare Program under the Medicare Secondary Payer rules.

Once we have made a payment for covered services, we shall have a lien on the proceeds of any judgment, settlement, or other award or recovery you receive, including but not limited to the following:

1. Any award, settlement, benefits, or other amounts paid under any workers compensation law or award;

2. Any and all payments made directly by or on behalf of a third-party tortfeasor or person, entity, or insurer responsible for indemnifying the third-party tortfeasor;

3. Any arbitration awards, payments, settlements, structured settlements, or other benefits or amounts paid under an uninsured or underinsured motorist coverage policy; or

4. Any other payments designated, earmarked, or otherwise intended to be paid to you as compensation, restitution, or remuneration for your injury, illness, or condition suffered as a result of the negligence or liability of a third party.

You agree to cooperate with us and any of our representatives and to take any actions or steps necessary to secure our lien, including but not limited to:

1. Responding to requests for information about any accidents or injuries;

2. Responding to our requests for information and providing any relevant information that we have requested; and

3. Participating in all phases of any legal action we commence in order to protect our rights, including but not limited to participating in discovery, attending depositions, and appearing and testifying at trial.

In addition, you agree not to do anything to prejudice our rights, including but not limited to assigning any rights or causes of action that you may have against any person or entity relating to your injury, illness, or condition without our prior express written consent. Your failure to cooperate shall be deemed a breach of your obligations, and we may institute a legal action against you to protect our rights.

Reimbursement

We are also entitled to be fully reimbursed for any and all benefit payments we make to you or on your behalf that are the responsibility of any person, organization, or insurer. Our right of reimbursement is separate and apart from our subrogation right, and is limited only by the amount of actual benefits paid under our plan. You must immediately pay to us any amounts you recover by judgment, settlement, award, recovery, or otherwise from any liable third party, his or her insurer, to the extent that we paid out or provided benefits for your injury, illness, or condition during your enrollment in our plan.

Antisubrogation rules do not apply

Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the "made whole" doctrine or any other equitable doctrine.

We are not obligated to pursue subrogation or reimbursement either for our own benefit or on your behalf. Our rights under Medicare law and this Evidence of Coverage shall not be affected, reduced, or eliminated by our failure to intervene in any legal action you commence relating to your injury, illness, or condition.

Chapter 10. Definitions of important words

Appeal - An appeal is something you do if you disagree with a decision to deny a request for health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a drug, item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Advanced Imaging Services - Computed Tomography Imaging (CT/CAT) Scan, Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), and Positron Emission Tomography (PET) Scan.

Allowed Amount - Individual charge determined by a carrier for a covered medical service or supply.

Ambulatory Surgical Center - A freestanding facility that provides medical surgical procedures on an outpatient basis for the prevention, diagnosis, and treatment of an injury or illness. This facility is staffed by physicians and provides treatment by, or under, the supervision of physicians as well as nursing care. This type of facility does not provide inpatient room and board and is Medicare-certified and licensed by the proper authority.

Balance Billing - A situation in which Private-Fee-for-Service plan providers (doctors or hospitals) can charge and bill you 15 percent more than the plan's payment amount for services.

Benefit Period - For both our Plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

Brand Name Drug - A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage - The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,550 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) - The Federal agency that runs Medicare. Chapter 2 explains how to contact CMS.

Coinsurance - The percentage of the charge for services and/or drugs that you may have to pay after you pay any plan deductibles. The coinsurance payment is a percentage of the cost of the service and/or drugs (like 20 percent) as determined by your plan.

Comprehensive Outpatient Rehabilitation Facility (CORF) - A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physician's services, physical therapy, social or psychological services, and outpatient rehabilitation.

Computed Tomography Imaging (CT/CAT) Scan - Combines the use of a digital computer together with a rotating X-ray device to create detailed cross-sectional images of different organs and body parts.

Contracted Rate - The rate the network provider and/or pharmacy has agreed to accept for covered services and/or prescription drugs.

Copayment - The fixed dollar amount you pay when you receive medical services and/or prescription drugs.

Cost-sharing - Cost-sharing refers to amounts that a member has to pay when drugs or services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs or services are covered; (2) any fixed "copayment" amounts that a plan may require be paid when specific drugs or services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a drug or service.

Coverage Determination - A decision about whether a medical service or drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the service or prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

Covered Drugs - The term we use to mean all of the prescription drugs covered by our Plan.

Covered Services - The general term we use to mean all of the health care services and supplies that are covered by our Plan.

Creditable Prescription Drug Coverage - Prescription drug coverage (for example, from an employer or union) that is expected to cover, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care - Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Customer Care Team - A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Care Team.

Deductible - The amount you must pay before our plan begins to pay its share of your covered medical services or drugs.

Diagnostic Mammogram - A radiological procedure furnished to a man or woman with signs or symptoms of breast disease.

Disenroll or **Disenrollment** - The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment - Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

Emergency Care - Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information - This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

Exception - A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary - A list of covered drugs provided by the plan.

Freestanding Dialysis Center - A freestanding facility that provides dialysis on an outpatient basis. This type of facility does not provide inpatient room and board and is Medicare-certified and licensed by the proper authority.

Freestanding Lab - A freestanding facility that provides laboratory tests on an outpatient basis for the prevention, diagnosis, and treatment of an injury or illness. This type of facility does not provide inpatient room and board and Medicare-certified and licensed by the proper authority.

Freestanding Radiology (Imaging) Center - A freestanding facility that provides one or more of the following services on an outpatient basis for the prevention, diagnosis, and treatment of an injury or illness: X-rays; nuclear medicine; radiation oncology. This type of facility does not provide inpatient room and board and Medicare-certified and licensed by the proper authority.

Generic Drug - A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Grievance - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Health Maintenance Organization (HMO) - A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

Home Health Aide - A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care - Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart under the heading "Home health care." If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice Care - A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and felief from pain. The focus is on care, not cure. For more information on hospice care, visit www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227). TYY users should call 1-877-486-2048.

Humana's National Transplant Network (NTN) - A network of Humana-approved facilities all of which are also Medicare-approved facilities.

Immediate Care Facility - A facility established to diagnose and treat an unforseen injury or illness on an outpatient basis. This facility is staffed by physicians and provides treatment by, or under, the supervision of physicians as well as nursing care. This type of facility does not provide inpatient room and board.

Initial Coverage Limit - The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage - This is the stage after you have met your deductible (if you have one) and before your total drug expenses, have reached $2,840, including amounts you've paid and what our Plan has paid on your behalf.

Inpatient Care - Health care that you get when you are admitted to a hospital.

Late Enrollment Penalty - An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

List of Covered Drugs (Formulary or "Drug Guide") - A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy/Extra Help - A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Magnetic Resonance Angiography (MRA) - A noninvasive method and a form of magnetic resonance imaging (MRI) that can measure blood flow through the blood vessels.

Magnetic Resonance Imaging (MRI) - A diagnostic imaging modality method that uses a magnetic field and computerized analysis of induced radio frequency signals to noninvasively image body tissue.

Medically Necessary - Drugs, services, or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare - The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization - Medicare Advantage plans are run by private companies. They give you more options, and sometimes, extra benefits. These plans are still part of the Medicare program and are also called "Part C." They provide all you Part A (Hospital) and Part B (Medical) coverage. Some may also provide Part D (Prescription Drug) coverage.

Medicare Advantage (MA) Plan - Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Allowable Charge - The amount allowed by Medicare for a particular benefit or service.

Medicare Limiting Charge - In the Original Medicare plan, the highest amount of money your can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. The limiting charge is 15 percent over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Medicare Prescription Drug Coverage (Medicare Part D) - Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy - Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") - A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network - A group of doctors, hospitals, pharmacies, and other health care experts/professionals contracted with a health plan to take care of its members.

Network Pharmacy - A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider - "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Non-Plan Provider or Non-Plan Facility - A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Non-plan providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers are not covered by our plan or Original Medicare.

Non-preferred Network Pharmacy *OR* **Other Network Pharmacy** - A network pharmacy that offers covered drugs to members of our Plan at higher cost-sharing levels than apply at a preferred network pharmacy.

Nuclear Medicine - Radiology in which radioisotopes (compounds containing radioactive forms of atoms) are introduced into the body for the purpose of imaging, evaluating organ function, or localizing disease or tumors.

Observation - A stay in a hospital for less than 24 hours if: (1) You have not been admitted as a registered bed patient; (2) you are physically detained in an emergency room, treatment room, observation room, or other such area; or (3) you are being observed to determine whether an inpatient confinement will be required.

Organization Determination - The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) - Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network Provider or Out-of-network Facility - A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-network Pharmacy - A pharmacy that doesn't have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Part C - see "Medicare Advantage (MA) Plan".

Part D - The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs - Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Provider - A general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them plan providers when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays plan providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services.

Point-of-Service (POS) Plan - A Medicare managed care plan option that lets you use doctors and hospitals outside the plan for an additional cost.

Positron Emission Tomography (PET) Scan - A medical imaging technique that involves injecting the patient with an isotope and using a PET scanner to detect the radiation emitted.

Preferred Network Pharmacy - A network pharmacy that offers covered drugs to members of our Plan at lower cost-sharing levels than apply at a non-preferred network pharmacy.

Preferred Provider Organization Plan - A Preferred Provider Organization plan is an MA plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers.

Prescription Drug Guide (Formulary) - A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Primary Care Physician (PCP) - A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Chapter 3 tells more about PCPs.

Prior Authorization - Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our Plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Private-Fee-for-Service (PFFS) Plan - A Private-Fee-for-Service plan is a plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk. Members of a PFFS plan may go to any doctor (and, for most plans, hospital) in the United States that is:

- Eligible to be paid by Medicare (that is, the provider (a) is state licensed, (b) is eligible to receive, or has received, a Medicare billing number, and (c) for Institutional providers, such as hospitals and skilled nursing facilities, is certified to treat Medicare beneficiaries); and

- Willing to accept the plan's terms of payment.

Quality Improvement Organization (QIO) - Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Chapter 2 for information about how to contact the QIO in your state and Chapter 7 for information about making complaints to the QIO.

Quantity Limits - A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services - These services include physical therapy, speech and language therapy, and occupational therapy.

Screening Mammogram - A radiological procedure for early detection of breast cancer, and; includes a physician's interpretation of the results.

Service Area - "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services.

Skilled Nursing Facility (SNF) Care - A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

Step Therapy - A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) - A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Care - Urgently needed care is a non-emergency situation when you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger. Because of the situation, it isn't reasonable for you to obtain medical care from a network provider.

Chapter 11. STATE SPECIFIC INFORMATION

Quality Improvement Organizations by State

ALASKA QIO
Mountain Pacific Quality Health Foundation
4241 B Street
Suite 303
Anchorage AK 99503
1-877-561-3202 (toll free)
1-907-561-3202 (local)
1-907-561-3204 fax
http://www.mpqhf.org/

ALABAMA QIO
AQAF
Two Perimeter Park South
Suite 200 West
Birmingham AL 35243
1-205-970-1600 (local)
1-205-970-1616 fax
http://www.aqaf.com/

ARKANSAS QIO
Arkansas Foundation for Medical Care
401 West Capitol
Suite 410
Little Rock AR 72201
1-888-987-1200 (toll free)
1-501-375-1200 (local)
1-888-354-9100 (medicare helpline)
1-888-285-1131 (TTY)
http://www.afmc.org

ARIZONA QIO
Health Services Advisory Group, Inc.
3133 East Camelback Road
Suite 300
Phoenix AZ 85016-4501
1-800-359-9909 (toll free)
1-602-264-6382 (local)
http://www.hsag.com/

CALIFORNIA QIO
Health Services Advisory Group
700 N. Brand Blvd
Suite 370
Glendale CA 91203
1-866-800-8749 (medicare helpline)
1-818-409-9229 (local)
1-800-881-5980 (TTY)
http://www.hsag.com/

COLORADO QIO
Colorado Foundation for Medical Care
23 Iverness Way East
Suite 100
Englewood CO 80112-5708
1-800-727-7086 (medicare helpline)
1-303-695-3300 (local)
http://www.cfmc.org/

CONNECTICUT QIO
Qualidigm
1111 Cromwell Avenue
Suite 201
Rocky Hill CT 06067-3454
1-800-553-7590 (medicare helpline)
1-860-632-2008 (local)
http://www.qualidigm.org/

DISTRICT OF COLUMBIA QIO
Delmarva Foundation for Medical Care
2175 K Street NW
Suite 250
Washington DC 20037
1-800-937-3362 (toll free)
1-202-293-9650 (local)
1-800-735-2258 (TTY)
http://www.dcqio.org/

DELAWARE QIO
Quality Insights of Delaware
Baynard Building, Suite 100
3411 Silverside Road
Wilmington DE 19810-4812
1-866-475-9669 (toll free)
1-302-478-3600 (local)
http://www.qide.org/de/

FLORIDA QIO
FMQAI
5201 West Kennedy Blvd
Suite 900
Tampa FL 33609-1822
1-800-844-0795 (medicare beneficiary)
1-813-354-9111 (local)
http://www.fmqai.com/

GEORGIA QIO
Georgia Medical Care Foundation
1455 Lincoln Parkway
Suite 800
Atlanta GA 30346
1-800-982-0411 (toll free)
1-678-527-3000 (local)
http://www.gmcf.org/

HAWAII QIO
Mountain-Pacific Quality Health Foundation
1360 S. Beretania Street
Suite 501
Honolulu HI 96814
1-800-524-6550 (toll free)
1-808-545-2550 (local)
1-808-440-6030 fax
http://www.mpqhf.org/

IOWA QIO
Iowa Foundation for Medical Care
1776 West Lakes Parkway
West Des Moines IA 50266
1-800-383-2856 (toll free)
1-515-223-2900 (local)
http://www.ifmc.org/

IDAHO QIO
QualisHealth
720 Park Blvd.
Suite 120
Boise ID 83712
1-800-488-1118 (toll free)
1-208-343-4617 (local)
http://www.qualishealthmedicare.org/

ILLINOIS QIO
IFMC-IL Illinois Foundation for Quality Health Care
711 Jorie Blvd
Suite #301
Oak Brook IL 60523-4425
1-800-647-8089 (toll free)
1-630-928-5800 (local)
http://www.ifqhc.org/

INDIANA QIO
Health Care Excel, Inc.
2629 Waterfront Parkway East Drive
Suite 200
Indianapolis IN 46214
1-800-288-1499 (toll free)
1-317-347-4500 (Indianapolis)
1-812-234-1499 (Terre Haute)
http://www.hce.org/

KANSAS QIO
Kansas Foundation for Medical Care, Inc.
2947 S.W. Wanamaker Drive
Topeka KS 66614-4193
1-800-423-0770 (toll free)
1-785-273-2552 (local)
http://www.kfmc.org/

KENTUCKY QIO
Health Care Excel
1941 Bishop Lane
Suite 400
Louisville KY 40218
1-800-288-1499 (toll free)
1-502-454-5112 (local)
http://www.hce.org/

LOUISIANA QIO
Louisiana Health Care Review, Inc.
8591 United Plaza Boulevard
Suite 270
Baton Rouge LA 70809
1-800-433-4958 (toll free)
1-225-926-6353 (local)
http://www.lhcr.org/

MASSACHUSETTS QIO
MassPRO
245 Winter Street
Waltham MA 02451-1231
1-800-334-6776 (toll free; in-state calls only)
1-781-890-0011 (local)
http://www.masspro.org/

MARYLAND QIO
Delmarva Foundation for Medical Care, Inc.
9240 Centreville Road
Easton MD 21601
1-800-999-3362 (toll free)
1-410-822-0697 (local)
http://www.mdqio.org/

MAINE QIO
Northeast Health Care Quality Foundation
15 Old Rollinsford Road
Suite 302
Dover NH 03820-2830
1-800-772-0151 (toll free)
1-603-749-1641 (local)
http://www.nhcqf.org/

MICHIGAN QIO
MPRO
22670 Haggerty Road
Suite 100
Farmington Hills MI 48335-2611
1-800-365-5899 (toll free)
1-248-465-7300 (local)
http://www.mpro.org/

MINNESOTA QIO
Stratis Health
2901 Metro Drive
Suite 400
Bloomington MN 55425-1525
1-877-787-2847 (toll free)
1-952-854-3306 (local)
1-800-627-3529 (TTY)
http://www.stratishealth.org/index.html

MISSOURI QIO
Primaris
200 North Keene Street
Columbia MO 65201
1-800-735-6776 (toll free)
1-573-817-8300 (local)
1-800-735-2966 (TTY)
http://www.primaris.org/

MISSISSIPPI QIO
Information and Quality Healthcare
385B Highland Colony Parkway
Suite 504
Ridgeland MS 39157
1-800-844-0500 (toll free)
1-601-957-1575 (local)
http://www.iqh.org/

MONTANA QIO
Mountain-Pacific Quality Health Foundation
3404 Cooney Drive
Helena MT 59602
1-800-497-8232 (toll free)
1-406-443-4020 (local)
1-406-443-4585 fax
http://www.mpqhf.org/

NORTH CAROLINA QIO
The Carolinas Center for Medical Excellence
100 Regency Forest Drive
Suite 200
Cary NC 27518-8598
1-800-682-2650 (toll free)
1-919-380-9860 (local)
1-800-735-2962 (TTY)
http://www.thecarolinascenter.org/

NORTH DAKOTA QIO
North Dakota Health Care Review Inc
800 31st Ave. SW
Minot ND 58701
1-701-852-4231 (local)
http://www.ndhcri.org/

NEBRASKA QIO
Cimro of Nebraska
1230 O Street
Suite 120
Lincoln NE 68508
1-800-458-4262 (toll free)
1-402-476-1399 (local)
http://www.cimronebraska.org/default.aspx

NEW HAMPSHIRE QIO
Northeast Health Care Quality Foundation
15 Old Rollinsford Road
Suite 302
Dover NH 03820
1-800-772-0151 (toll free)
1-603-749-1641 (local)
http://www.nhcqf.org/

NEW JERSEY QIO
Healthcare Quality Strategies
557 Cranbury Road
Suite 21
East Brunswick NJ 08816-5419
1-800-624-4557 (toll free)
1-732-238-5570 (local)
http://www.pronj.org

NEW MEXICO QIO
New Mexico Medical Review Association
5801 Osuna Road NE
Suite 200
Albuquerque NM 87109
1-800-663-6351 (toll free)
1-505-998-9898 (local)
http://www.nmmra.org/

NEVADA QIO
Health Insight
6830 W. Oquendo Road
Suite 102
Las Vegas NV 89118
1-800-748-6773 (toll free)
1-702-385-9933 (local)
http://www.healthinsight.org/

NEW YORK QIO
Island Peer Review Organization - IPRO
1979 Marcus Avenue
Lake Success NY 11042-1002
1-800-648-4776 (toll free)
1-516-326-7767 (local)
1-866-326-6182 (TTY)
http://www.ipro.org/

OHIO QIO
Ohio KePRO, Inc.
Rock Run Center, Suite 100
5700 Lombardo Center Drive
Seven Hills OH 44131
1-800-589-7337 (toll free)
1-216-447-9604 (local)
http://www.ohiokepro.com/

OKLAHOMA QIO
Oklahoma Foundation for Medical Quality, Inc.
14000 Quail Springs Parkway
Suite 400
Oklahoma City OK 73134-2600
1-800-522-3414 (toll free)
1-405-840-2891 (local)
http://www.ofmq.com/

OREGON QIO
Acumentra Health
2020 SW Fourth Ave.
Suite 520
Portland OR 97201
1-800-344-4354 (toll free)
1-503-279-0100 (local)
http://www.acumentra.org/

PENNSYLVANIA QIO
Quality Insights of Pennsylvania
2601 Market Place Street
Suite 320
Harrisburg PA 17110
1-877-346-6180 (toll free)
1-717-671-5425 (local)
http://www.qipa.org/pa/

PUERTO RICO QIO
QI PRO, Inc.
2 Ponce de Leon Ave
Mercantil Plaza Bldg Suite 709
San Juan PR 00918
1-877-566-0566 (toll free)
1-787-641-1240 (local)
1-877-881-8812 (TTY)
http://www.qipro.org/

RHODE ISLAND QIO
Quality Partners of Rhode Island
235 Promenade Street
Suite 500, Box 18
Providence RI 02908
1-800-662-5028 (toll free)
1-401-528-3200 (local)
http://www.qualitypartnersri.org/

SOUTH CAROLINA QIO
The Carolinas Center for Medical Excellence
246 Stoneridge Drive
Suite 200
Columbia SC 29210
1-800-922-3089 (toll free; in-state calls only)
1-803-251-2215 (local)
1-800-735-8583 (TTY)
http://www.thecarolinascenter.org/

SOUTH DAKOTA QIO
South Dakota Foundation for Medical Care, Inc.
2600 West 49th Street
Suite 300
Sioux Falls SD 57105
1-800-MEDICARE (toll free)
1-605-336-3505 (local)
http://www.sdfmc.org/

TENNESSEE QIO
Qsource
3175 Lenox Park Blvd
Suite 309
Memphis TN 38115
1-800-528-2655 (toll free Memphis)
http://www.qsource.org/

TEXAS QIO
Texas Medical Foundation - TMF
BridgePoint I Suite 300
5918 West Courtyard Drive
Austin TX 78730-5036
1-800-725-9216 (toll free)
1-512-329-6610 (local)
1-877-486-2048 (TTY)
http://www.tmf.org/

UTAH QIO
HealthInsight
348 East 4500 South
Suite 300
Salt Lake City UT 84107
1-800-748-6773 (toll free)
1-801-892-0155 (local)
http://www.healthinsight.org/

VIRGINIA QIO
Virginia Health Quality Center
9830 Mayland Drive
Suite J
Richmond VA 23233
1-866-263-8402 (toll free)
1-804-289-5320 (local)
http://www.vhqc.org/

VERMONT QIO
Northeast Health Care Quality Foundation
15 Old Rollinsford Road
Suite 302
Dover NH 03820-2830
1-800-772-0151 (toll free)
1-603-749-1641 (local)
http://www.nhcqf.org/

WASHINGTON QIO
QualisHealth
PO Box 33400
Seattle WA 98133-0400
1-800-949-7536 (toll free)
1-206-364-9700 (local)
711 (TTY)
http://www.qualishealthmedicare.org/

WISCONSIN QIO
MetaStar, Inc.
2909 Landmark Place
Madison WI 53713
1-800-362-2320 (toll free)
1-608-274-1940 (local)
http://www.metastar.com/web/

WEST VIRGINIA QIO
WVMI Quality Insights
3001 Chesterfield Avenue
Charleston WV 25304
1-800-642-8686 (toll free)
1-304-346-9864 (local)
http://www.qiwv.org/wv/

WYOMING QIO
Mountain-Pacific Quality Health Foundation
PO Box 2242
Glenrock WY 82637
1-877-810-6248 (toll free)
1-307-436-8733 (local)
1-307-436-7176 fax
http://www.mpqhf.org/

State Health Insurance Assistance Programs(SHIPs) by State

ALASKA SHIP
Alaska State Health Insurance Assistance Program (SHIP)
1217 E. 10th Ave
Anchorage AK 99501
1-800-478-6065 (toll free; in-state calls only)
1-907-269-3680 (local)
1-907-269-3691 (TTY)
http://www.hss.state.ak.us/dsds/medicare/

ALABAMA SHIP
State Health Insurance Assistance Program (SHIP)
Alabama Department of Senior Services
770 Washington Avenue, RSA Plaza 570
Montgomery AL 36130-1851
1-800-243-5463 (toll free)
1-334-242-5743 (local)
http://www.alabamaageline.gov/healthcare

ARKANSAS SHIP
Senior Health Insurance Information Program (SHIIP)
1200 West Third Street
Little Rock AR 72201
1-800-224-6330 (toll free)
1-501-371-2782 (local)
http://insurance.arkansas.gov/seniors/homepage.htm

ARIZONA SHIP
Arizona State Health Insurance Assistance Program (SHIP)
1789 West Jefferson St. 950A
Phoenix AZ 85007
1-800-432-4040 (SHIP Hotline)
1-602-542-4446 (local)
http://www.azdes.gov/aaa/programs/ship/default.asp

CALIFORNIA SHIP
Health Insurance Counseling & Advocacy Program (HICAP)
1300 National Drive
Suite 200
Sacramento CA 95834-1992
1-800-434-0222 (toll free)
1-916-419-7500 (local)
1-800-735-2929 (TTY)
http://www.aging.ca.gov/HICAP/

COLORADO SHIP
Senior Health Insurance Assistance Program (SHIP)
1560 Broadway
Suite 850
Denver CO 80202
1-888-696-7213 (toll free)
1-303-629-4940 (local)
1-866-665-9668 (Spanish)
1-303-894-7880 (TTY)
www.dora.state.co.us/insurance/senior/senior.htm

CONNECTICUT SHIP
Connecticut Program for Health Insurance Assistance,
Outreach, Information & Referral Counseling and
Eligibility Screening (CHOICES)
25 Sigourney Street
10th Floor
Hartford CT 06106
1-866-218-6631 (toll free; in-state calls only)
1-860-424-5274 (local)
http://www.ct.gov/agingservices

DISTRICT OF COLUMBIA SHIP
Health Insurance Counseling Project (HICP)
2136 Pennsylvania Ave. NW
Washington DC 20052
1-202-739-0668 (local)
1-202-973-1079 (TTY)
http://www.law.gwu.edu/Academics/EL/clinics/insurance/Pages/About.aspx

DELAWARE SHIP
ELDERinfo
841 Silver Lake Blvd.
Dover DE 19904
1-800-336-9500 (toll free: in-state calls only)
1-302-674-7364 (local)
http://delawareinsurance.gov/departments/elder/eldindex.shtml

FLORIDA SHIP
SHINE
4040 Esplanade Way
Tallahassee FL 32399-7000
1-800-963-5337 (toll free)
1-850-414-2060 (local)
1-850-414-2001 (TTY)
http://www.floridaSHINE.org

GEORGIA SHIP
GeorgiaCares
2 Peachtree Street, NW
Suite 9-385
Atlanta GA 30303
1-800-669-8387 (toll free)
1-404-657-5334 (local)
1-404-657-1929 (TTY)
www.dhr.georgia.gov

HAWAII SHIP
Sage PLUS
250 South Hotel Street
Room 406
Honolulu HI 96813
1-888-875-9229 (toll free)
1-808-586-7299 (local)
1-866-810-4379 (TTY)
www.hawaii.gov/health/eoa

IOWA SHIP
Senior Health Insurance Information Program (SHIIP)
330 Maple St.
Des Moines IA 50319
1-800-351-4664 (toll free)
1-515-281-5705
1-800-735-2942 (TTY)
http://www.shiip.state.ia.us/

IDAHO SHIP
Senior Health Insurance Benefit Advisors of Idaho (SHIBA)
700 West State Street
3rd floor
Boise ID 83720-0043
1-800-247-4422 (toll free; in-state calls only)
1-208-334-4250 (local)
http://www.doi.idaho.gov/shiba/shwelcome.aspx

ILLINOIS SHIP
Senior Health Insurance Program of Illinois (SHIP)
320 West Washington Street
Springfield IL 62767-0001
1-800-548-9034 (toll free; in-state calls only)
1-217-785-9021 (local)
1-217-524-4872 (TTY)
http://insurance.illinois.gov/ship/

INDIANA SHIP
State Health Insurance Assistance Program (SHIP)
714 West 53rd Street
Anderson IN 46013
1-800-452-4800 (toll free)
1-765-608-2318 (local)
1-866-846-0139 (TTY)
http://www.in.gov/idoi/2495.htm

KANSAS SHIP
Senior Health Insurance Counseling for Kansas (SHICK)
503 S. Kansas
Topeka KS 66603-3404
1-800-860-5260 (toll free)
1-316-337-7386 (local)
1-785-291-3167 (TTY)
http://www.agingkansas.org/

KENTUCKY SHIP
State Health Insurance Assistance Program (SHIP)
275 East Main Street
Frankfort KY 40621
1-877-293-7447 (toll free)
1-502-564-6930 (local)
1-888-642-1137 (TTY)
http://www.chfs.ky.gov/dail/ship.htm

LOUISIANA SHIP
Senior Health Insurance Information Program (SHIIP)
P.O. Box 94214
Baton Rouge LA 70804
1-800-259-5301 (toll free; in-state calls only)
1-255-342-5301 (local)
http://www.ldi.state.la.us/Health/SHIIP/index.htm

MASSACHUSETTS SHIP
Serving Health Information Needs of Elders (SHINE)
1 Ashburton Place 5th Floor
Boston MA 02108
1-800-243-4636 (toll free)
1-617-727-7750 (local)
1-800-872-0166 (TTY)
www.mass.gov/elders

MARYLAND SHIP
Senior Health Insurance assistance Program (SHIP)
301 West Preston Street Room 1007
Baltimore MD 21201
1-800-243-3425 (toll free; in-state calls only)
1-410-767-1100 (local)
1-410-767-1083 (TTY)
http://www.mdoa.state.md.us/senior.html

MAINE SHIP
Maine State Health Insurance Assistance Program (SHIP)
11 State House Station
32 Blossom Lane-2nd Floor
Augusta ME 04333
1-877-353-3771 (toll free; in-state calls only)
1-207-621-0087 (local)
1-800-606-0215 (TTY)
http://www.maine.gov/dhhs/oes/hiap/index.shtml

MICHIGAN SHIP
MMAP Inc
6105 West St. Joseph Suite 204
Lansing MI 48917-4850
1-800-803-7174 (toll free)
1-517-886-1242 (local)
www.mmapinc.org

MINNESOTA SHIP
Minnesota State Health Insurance Assistance Program/Senior Link
PO box 64976
St. Paul MN 55164-0976
1-800-333-2433 (toll-free)
1-651-431-2500 (local)
1-800-627-3529 (TTY)
http://www.mnaging.org/advisor/SLL_SHIP.htm

MISSOURI SHIP
CLAIM
PO Box 690, Truman Bldg
Jefferson City MO 65102
1-800-390-3330 (toll free)
1-573-817-8320 (local)
www.missouriclaim.org

MISSISSIPPI SHIP
MS State Health Insurance Assistance Program (SHIP)
750 North State Street
Jackson MS 39202
1-800-948-3090 (toll free)
1-601-359-4929 (local)
1-800-676-4154 (TTY)
http://www.mdhs.state.ms.us/aas_info.html

MONTANA SHIP
Montana State Health Insurance Assistance Program (SHIP)
PO Box 4210
Helena MT 59601-4210
1-800-551-3191 (toll free; in-state calls only)
1-406-444-4077
771 (TTY)
http://www.dphhs.mt.gov/sltc/services/aging/ship.shtml

NORTH CAROLINA SHIP
Seniors' Health Insurance Information Program (SHIIP)
11 South Boylan Avenue
Raleigh NC 27603
1-800-443-9354 (toll free; in-state calls only)
1-919-807-6900 (local)
1-800-735-2962 (TTY)
http://www.ncdoi.com/shiip/default.asp

NORTH DAKOTA SHIP
State Health Insurance Counseling (SHIC)
600 East Boulevard
State Capitol Floor 5
Bismarck ND 58505-0320
1-888-575-6611 (toll free; in-state calls only)
1-701-328-2440 (local)
1-800-366-6888 (TTY)
http://www.nd.gov/ndins/consumer/shic/

NEBRASKA SHIP
Nebraska Senior Health Insurance Information Program (SHIIP)
941 O Street
Suite 400
Lincoln NE 68508-3690
1-800-234-7119 (toll free)
1-402-471-2201 (local)
1-800-833-7352 (TTY)
http://www.doi.ne.gov/shiip

NEW HAMPSHIRE SHIP
NH SHIP - ServiceLink Resource Center
129 Pleasant Street
Gallen State Office Park
Concord NH 03301-3857
1-866-634-9412 (toll free; in-state calls only)
1-800-735-2964 (TDD)
www.servicelink.org

NEW JERSEY SHIP
New Jersey Department of Health and Senior Services
Division of Aging and Community Services
PO Box 360
Trenton NJ 08625-0360
1-800-792-8820 (toll free; in-state calls only)
1-877-222-3737 (toll free)
www.state.nj.us/health/senior/ship.shtml

NEW MEXICO SHIP
Benefits Counseling Program
2550 Cerrillos Road
Santa Fe NM 87505
1-800-432-2080 (toll free; in-state calls only)
1-505-476-4799 (local)
www.nmaging.state.nm.us

NEVADA SHIP
State Health Insurance Advisory Program of Nevada (SHIP)
3416 Goni Road
Bldg. D, #132
Carson City NV 89706
1-800-307-4444 (toll free)
1-702-486-3478 (local)
www.nvaging.net/ship/ship_main.htm

NEW YORK SHIP
Health Insurance Information Counseling and Assistance Program (HIICAP)
2 Empire State Plaza
Agency Bldg #2
4th Floor
Albany NY 12223-1251
1-800-701-0501 (toll free)
1-800-342-9871 (toll free)
www.aging.ny.gov

OHIO SHIP
Ohio Senior Health Insurance Information Program (OSHIIP)
50 West Town Street
3rd floor, Suite 300
Columbus OH 43215
1-800-686-1578 (toll free)
1-614-644-3458 (local)
1-614-644-3745 (TTY)
http://www.insurance.ohio.gov/Pages/default.aspx

OKLAHOMA SHIP
Senior Health Insurance Counseling Program (SHIP)
2401 N.W. 23rd
Suite 28
Oklahoma City OK 73107
1-800-763-2828 (toll free; in-state calls only)
1-405-521-6628 (local)
http://www.ok.gov/oid/Consumers/Information_for_Seniors/Senior_Health_Insuranc
e_Counseling_Program_(SHIP)/index.html

OREGON SHIP
Senior Health Insurance Benefits Assistance (SHIBA)
350 Winter St NE, PO Box 14480
Suite 330
Salem OR 97309-0405
1-800-722-4134 (toll free)
1-503-378-2014 (local)
1-800-735-2900 (TTY)
http://www.oregon.gov/DCBS/SHIBA/

PENNSYLVANIA SHIP
APPRISE
555 Walnut Street 5th Floor
Harrisburg PA 17101-1919
1-800-783-7067 (toll free)
1-215-765-9041 (TDD)
http://www.pcacares.org/pca_ss_APPRISE.aspx

PUERTO RICO SHIP
State Health Insurance Assistance Program (SHIP)
PO Box 191179
San Juan PR 00919-1179
1-877-725-4300 (toll free San Juan, Ponce)
1-800-981-7735 (toll free Mayag)
1-787-721-6121 (local)
www.oppea.gobierno.pr

RHODE ISLAND SHIP
Senior Health Insurance Program (SHIP)
John O. Pastore Complex, Hazard Building
74 West Road
Cranston RI 02920
1-401-462-4444 (local)
1-401-462-0740 (TTY)
http://www.dea.ri.gov/insurance/

SOUTH CAROLINA SHIP
Insurance Counseling Assistance and Referrals for Elders Program (I-CARE)
1301 Gervais Street
Suite 200
Columbia SC 29202
1-800-868-9095 (toll free)
1-803-734-9900 (local)
http://www.aging.sc.gov/Seniors/ICARE.htm

SOUTHDAKOTA SHIP
Senior Health Information and Insurance Education (SHIINE)
700 Governors Drive
Pierre SD 57501-2291
1-800-536-8197 (toll free)
1-605-333-3314 (local)
711 (TTY - in-state only)
www.shiine.net

TENNESSEE SHIP
TN SHIP
500 Deaderick St.
Nashville TN 37243-0860
1-877-801-0044 (toll free)
1-615-741-2056 (local)
1-615-532-3893 (TTY)
http://www.state.tn.us/comaging/ship.html

TEXAS SHIP
Health Information Counseling and Advocacy Program (HICAP)
701 West 51st Street
Austin TX 78751
1-800-252-9240 (toll free)
1-800-735-2989 (TTY)
http://www.dads.state.tx.us/

UTAH SHIP
Senior Health Insurance Information Program (SHIP)
195 North 1950 West
Salt Lake City UT 84116
1-800-541-7735 (toll free)
1-801-538-3910 (local)
http://www.hsdaas.utah.gov/insurance_programs.htm

VIRGINIA SHIP
Virginia Insurance Counseling and Assistance Program (VICAP)
1610 Forest Avenue
Suite 100
Richmond VA 23229-5009
1-800-552-3402 (toll free)
1-804-662-9333 (local)
1-804-662-9334 (local)
1-800-552-3402 (TTY)
www.vda.virginia.gov

VERMONT SHIP
State Health Insurance Assistance Program (SHIP)
481 Summer Street
Suite 101
St. Johnsbury VT 05819
1-800-642-5119 (toll free; in-state calls only)
1-802-748-5182 (local)
www.medicarehelpvt.net

WASHINGTON SHIP
Statewide Health Insurance Benefits Advisors (SHIBA) Helpline
P.O. Box 40256
Olympia WA 98504-0256
1-800-562-6900 (toll free)
1-360-586-0241 (TTY)
http://www.insurance.wa.gov/shiba/index.shtml

WISCONSIN SHIP
Wisconsin SHIP
1 West Wilson Street
Madison WI 53703
1-800-242-1060 (toll free)
1-866-456-8211 (toll free)
1-608-267-3201 (local)
1-866-796-9725 (TTY)
http://dhs.wisconsin.gov/aging/SHIP.htm

WEST VIRGINIA SHIP
West Virginia State Health Insurance Assistance Program (WV SHIP)
1900 Kanawha Blvd. East
Charleston WV 25305-0160
1-877-987-4463 (toll free)
1-304-558-3317 (local)
www.wvship.org

WYOMING SHIP
Wyoming State Health Insurance Information Program (WSHIIP)
106 West Adams Ave
Riverton WY 82501
1-800-856-4398 (toll free)
1-307-856-6880
www.wyomingseniors.com

State Medicaid Office(SMO) by State

ALASKA SMO
Alaska Department of Health and Social Services
Senior and Disabilities Services
751 Old Richarson Hwy
Suite 100a
Fairbanks AK 99701
1-800-770-1672 (toll free)
1-907-451-5045 (local)
1-907-451-5093 (TTY)

ALABAMA SMO
Medicaid Agency of Alabama
P.O. Box 5624
Montgomery AL 36103-5624
1-800-362-1504 (toll free)
1-334-242-5000 (local)
http://www.medicaid.alabama.gov/

ARKANSAS SMO
Division of Medical Services-Department of Human Services
Donaghey Complex
700 Main St
Little Rock AR 72201
1-800-482-5431 (in-state toll free)
1-501-682-1001 (local and out of state)
1-800-482-8988 (Spanish- in-state toll free)
1-501-682-1661 (TTY)
http://www.arkansas.gov/dhs/homepage.html

ARIZONA SMO
AHCCCS
801 E. Jefferson St. MD 4100
Phoenix AZ 85034
1-800-654-8713 (toll free)
1-602-417-4000 (local)
http://www.azahcccs.gov/

CALIFORNIA SMO
Department of Health Care Services
Medi-Cal
PO Box 13029
Sacramento CA 95813-4029
1-800-541-5555 (toll-free in state only)
1-916-636-1200 (local)
http://www.medi-cal.ca.gov/

COLORADO SMO
Department of Health Care Policy and Financing
1570 Grant Street
Denver CO 80203
1-800-221-3943 (toll free)
1-303-866-3513 (local)
1-800-659-2656 (TTY)
http://www.colorado.gov/hcpf

CONNECTICUT SMO
State of Connecticut Department of Social Services
25 Sigourney Street
Hartford CT 06106-5033
1-800-842-1508 (toll free; in-state calls only)
1-860-424-4908 (local)
1-800-842-4524 (TTY)
http://www.ct.gov/dss/site/default.asp

DISTRICTOF COLUMBIA SMO
Department of Health
825 North Capitol Street, NE Suite 5135
Washington DC 20002
1-202-442-5955 (local)
1-800-367-9559 (TTY)
http://dchealth.dc.gov/doh/site/default.asp

DELAWARE SMO
Division of Services for Aging and Adults with Physical Disabilities
Lewis Building
1901 N. DuPont Highway
New Castle DE 19720
1-800-223-9074 (toll free)
1-302-255-9390 (local)
1-302-391-3505 (TDD)
http://dhss.delaware.gov/dsaapd/

FLORIDA SMO
Agency for Health Care Administration of Florida
2727 Mahan Drive
Tallahassee FL 32308
1-888-419-3456 (toll free; in-state calls only)
http://ahca.myflorida.com/

GEORGIA SMO
Georgia Department of Community Health
2 Peachtree Street
Atlanta GA 30303
1-404-656-4507 (local)
http://dch.georgia.gov/

HAWAII SMO
Med-Quest
601 Kamokila Blvd, Room 518
Kapolei HI 96707
1-808-586-5390 (local)
1-808-692-7182 (TTY)

IOWA SMO
Iowa Department of Human Services
P. O. Box 36510
Des Moines IA 50315
1-800-338-8366 (toll free)
1-515-725-1003 (local)

IDAHO SMO
Idaho Department of Health and Welfare
P.O. Box 83720
Boise ID 83720
1-800-926-2588 (toll free)
1-208-334-0618 (local)
1-208-334-0901 (TTY)

ILLINOIS SMO
Illinois Health Connect
1375 East Woodfield Rd
Suite 600
Schaumburg IL 60173-5418
1-877-912-1999 (toll free)
1-866-565-8577 (TTY)
http://www.illinoishealthconnect.com/

INDIANA SMO
Family and Social Services Administration of Indiana
402 West Washington Street
P.O. Box 7083
Indianapolis IN 46207-7083
1-800-889-9949 (toll free)
1-317-233-9435 (local)
http://www.in.gov/fssa/elderly/hoosierrx/

KANSAS SMO
Department of Social and Rehabilitation Services of Kansas
915 SW Harrison St
Topeka KS 66612
1-888-369-4777 (local)
1-785-296-3959 (local)
1-785-296-1491 (TTY)
http://www.srskansas.org/

KENTUCKY SMO
Cabinet for Health Services of Kentucky
275 East Main Street
Frankfort KY 40621
1-800-372-2973 (toll free)
1-502-564-4321 (local)
1-800-627-4702 (TTY)
http://chfs.ky.gov/

LOUISIANA SMO
Louisiana Department of Health and Hospital
628 N. 4th St.
Baton Rouge LA 70802
1-225-342-9500 (local)
http://www.dhh.louisiana.gov/

MASSACHUSETTS SMO
Executive Office of Elder Affairs
One Ashburton Place
Room 517
Boston MA 02108
1-800-882-2003 (toll free; in-state calls only)
1-617-727-7750 (local)
1-800-872-0166 (TTY)
http://www.mass.gov/?pageID=eldershomepage&L=1&L0=Home&sid=Eelders

MARYLAND SMO
The Maryland Department of Aging
301 West Preston St.
Suite 1700
Baltimore MD 21201
1-800-243-3425 (toll free)
1-410-767-1100 (local)
1-800-201-7165 (TTY)
http://www.mdoa.state.md.us/

MAINE SMO
Office of MaineCare Services
11 State House Station
Augusta ME 04333-0011
1-800-977-6740 (option 2) (toll free)
1-207-287-9202 (main number)
1-800-606-0215 (TTY)
http://www.maine.gov/dhhs/oms/

MICHIGAN SMO
Michigan Department Community Health
Capitol View Building
201 Townsend Street
Lansing MI 48913
1-517-373-3740 (local)
1-800-649-3777 (TTY)
http://www.michigan.gov/mdch

MINNESOTA SMO
Minnesota Board on Aging
PO Box 64976
St. Paul MN 55164-0976
1-800-882-6262 (toll free)
1-651-431-2500 (local)
1-800-627-3529 (TTY)
http://www.mnaging.org/

MISSOURI SMO
Department of Social Services of Missouri
221 West High Street
P.O. Box 1527
Jefferson City MO 65102-1527
1-800-392-2161 (toll free; in-state calls only)
1-573-751-4815 (local)
1-800-735-2466 (TTY)
http://www.dss.mo.gov/

MISSISSIPPI SMO
Mississippi Division of Medicaid
Sillers Building, 550 High Street
Suite 1000
Jackson MS 39201-1399
1-800-421-2408 (toll free)
1-601-359-6050 (local)
http://www.medicaid.ms.gov/

MONTANA SMO
Montana Department of Public Health and Human Services
Division of Child and Adult Health Resources
1400 Broadway Cogswell Building
Helena MT 59620
1-800-362-8312 (toll free; in-state calls only)
1-406-444-4540 (local)
711 (TTY)

NORTH CAROLINA SMO
Division of Medical Assistance - recipient services
2501 Mail Sservice Center
Raleigh NC 27699-2501
1-919-855-4100 (local)
1-800-622-7030 Care-Line Information and Referral Service:English/Spanish
1-919-855-4400 (Spanish)
1-877-733-4851 (TTY)
http://www.dhhs.state.nc.us/DMA/

NORTH DAKOTA SMO
North Dakota Department of Human Services
600 East Blvd. Ave
Dept 325
Bismarck ND 58505-0250
1-800-472-2622 (toll free)
1-701-328-2310 (local)
1-701-328-3480 (TTY)
http://www.nd.gov/dhs/

NEBRASKA SMO
Nebraska Department of Health and Human Services System
P.O. Box 95026
Lincoln NE 68509-5026
1-800-430-3244 (toll free)
1-402-471-3121 (local)
1-402-471-9570 (TTY)
http://www.hhs.state.ne.us/

NEW HAMPSHIRE SMO
New Hampshire Department of Health and Human Services
105 Pleasant Street
Concord NH 03301
1-800-852-3345 x8166 (toll free; in-state calls only)
1-603-271-4322 (local)

NEW JERSEYSMO
Department of Human Services of New Jersey
Quakerbridge Plaza
P.O. Box 712
Trenton NJ 08625-0712
1-800-356-1561 (toll free; in-state calls only)
1-609-588-2600 (local)
1-800-356-1561 (Spanish)

NEW MEXICO SMO
Human Services Department
Medical Assistance Division
P.O. Box 2348
Santa Fe NM 87504-2348
1-888-997-2583 (toll free)
1-505-827-3100 (local Sante Fe)
1-800-432-6217 (Spanish)
http://www.hsd.state.nm.us/mad/

NEVADA SMO
Nevada Department of Human Resources
Aging Division
1210 S. Valley View
Las Vegas NV 89102
1-800-992-0900 (toll free)
1-775-684-7200 (local)

NEW YORK SMO
Benefits Counseling Program
Corning Tower Building
2 Empire State Plaza
Albany NY 12223-1251
1-800-342-9871 (toll free)
1-518-486-9057 (local)
http://www.aging.ny.gov/HealthBenefits/Index.cfm

OHIO SMO
The Ohio Department of Job and Family Services
30 E. Broad Street
32nd Floor
Columbus OH 43215
1-877-852-0010 (toll free)
1-614-466-2100 (local)
http://jfs.ohio.gov/

OKLAHOMA SMO
Oklahoma Health Care Authority
2401 N.W. 23rd St.
Suite 1A
Oklahoma City OK 73107
1-800-987-7767 (toll free)
1-405-522-7171 (local)
1-405-522-7300 (local)
1-405-522-7179 (TTY)
http://okhca.org/

OREGON SMO
Oregon Department of Human Services
500 Summer Street, NE
Salem OR 97301
1-800-527-5772 (toll free; in-state calls only)
1-503-945-5994 (local)
1-503-945-6214 (TTY)
http://www.oregon.gov/DHS/

PENNSYLVANIA SMO
Department of Public Welfare of Pennsylvania
Health and Welfare Building
Rm. 515, P.O. Box 2675
Harrisburg PA 17105-2675
1-800-692-7462 (toll free)
1-717-787-1870 (local)
1-717-705-7103 (TTY)
http://www.dpw.state.pa.us/

PUERTO RICO SMO
Medicaid Office of Puerto Rico and Virgin Island
GPO Box 70184
San Juan PR 00936
1-787-250-0453 (local)

RHODE ISLAND SMO
Department of Human Services of Rhode Island
Louis Pasteur Building
600 New London Avenue
Cranston RI 02920
1-800-984-8989 (toll free; in-state calls only)
1-401-462-5300 (local)
1-401-462-3363 (TTY)

SOUTH CAROLINA SMO
South Carolina Department of Health & Human Services
P.O. Box 8206
Columbia SC 29202
1-888-549-0820 (toll free)
1-803-898-2500 (local)
http://www.dhhs.state.sc.us/

SOUTH DAKOTA SMO
Department of Social Services of South Dakota
700 Governors Drive
Pierre SD 57501
1-800-452-7691 (toll free; in-state calls only)
1-605-773-3165 (local)
1-800-305-9673 (Spanish)
http://dss.sd.gov/

TENNESSEE SMO
Bureau of TennCare
310 Great Circle Road
Nashville TN 37243
1-800-342-3145 (toll free)
1-800-772-7647 (TTY)
http://www.state.tn.us/tenncare/

TEXAS SMO
Health and Human Services Commission of Texas
4900 N. Lamar Blvd
Austin TX 78751
1-877-541-7905 (toll free; in-state calls only)
1-512-424-6500 (local)
1-512-424-6597 (TTY)
http://www.hhsc.state.tx.us/

UTAH SMO
Utah Department of Health
Cannon Health Building
288 North 1460 West
Salt Lake City UT 84116
1-800-662-9651 (toll free)
1-801-538-6101 (local)
1-800-662-9651 (Spanish)
http://health.utah.gov/

VIRGINIA SMO
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond VA 23219
1-804-786-7933 (local)
1-800-343-0634 (TTY)
http://www.dmas.virginia.gov/

VERMONT SMO
The Office of Vermont Health Access
312 Hurricane Lane
Suite 201
Williston VT 05495
1-800-250-8427 (toll free; in-state calls only)
1-802-879-5900 (local)
http://ovha.vermont.gov/

WASHINGTON SMO
Department of Social and Health Services of Washington
Aging and Disability Services Administration
640 Woodland Square Loop
Lacey WA 98503
1-800-422-3263 (toll free; in-state calls only)
1-360-725-2460 (local)
1-877-905-0454 (TTY)

WISCONSIN SMO
Wisconsin Department of Health and Family Services
1 West Wilson Street
Madison WI 53703
1-800-362-3002 (toll free)
1-608-266-1865 (local)
1-608-267-7371 (TTY)
http://www.dhs.wisconsin.gov/

WEST VIRGINIA SMO
West Virginia Department of Health & Human Resources
State Capitol Complex
Building 3 Room 206
Charleston WV 25305
1-304-558-0684 (local)
1-304-558-4398 (local)
http://www.wvdhhr.org/

WYOMING SMO
Wyoming EqualityCare
6101 Yellowstone Rd, Ste 210
Cheyenne WY 82002
1-307-777-7531 (local)
1-307-777-5648 (TTY)
https://wyequalitycare.acs-inc.com/wy/general/clientHome.do

State Pharmaceutical Assistance Program(SPAPs) by State

CONNECTICUT SPAP
Connecticut Pharmaceutical Assistance Contract to the
Elderly and Disabled Program (ConnPACE)
PO Box 5011
Hartford CT 06102
1-800-423-5026 (toll free)
1-860-269-2029 (local)
http://www.connpace.com/

DELAWARE SPAP
Delaware Prescription Assistance Program
P.O. Box 950
New Castle DE 19720-0950
1-800-996-9969 (option 2, then option1)
http://www.dhss.delaware.gov/dss/dpap.html

HAWAII SPAP
State Pharmacy Assistance Program
P.O. Box 700220
Kapolei HI 96709
1-866-878-9769

ILLINOIS SPAP
Illinois Cares RX Illinois Department on Aging
P.O. Box 19003
Springfield IL 62794-9003
1-800-252-8966 (Senior help line)
1-800-624-2459 (24 hr automated information)
1-888-206-1327 (TTY)
www.illinoiscaresrx.com

INDIANA SPAP
Hoosier RX
P.O. Box 6224
Indianapolis IN 46206-6224
1-866-267-4679 (toll free, in state only)
1-317-234-1381 (local)
http://www.in.gov/fssa/ompp/2669.htm

MASSACHUSETTS SPAP
Massachusetts Prescription Advantage
P.O. Box 15153
Worcester MA 01615-0153
1-800-243-4636 (toll free)
1-877-610-0241 (TTY)
www.800ageinfo.com

MARYLAND SPAP
Maryland Senior Prescription Drug Assistance Program
Maryland SPDAP c/o Pool Administrators
100 Great Meadow Road
Suite 705
Wethersfield CT 06109
1-800-551-5995 (toll free)
1-800-877-5156 (TTY)
www.marylandspdap.com

MAINE SPAP
Maine Low Cost Drugs for the Elderly or Disabled Program
Office of MaineCare Services
442 Civic Center Drive
Augusta ME 04333
1-866-796-2463
1-207-287-9200 (local)
1-800-606-0215 (TYY)
http://www.maine.gov/dhhs/oes/resource/lc_drugs.htm

MISSOURI SPAP
Missouri RX Plan
615 Howerton Court
PO Box 6500
Jefferson City MO 65102-6500
1-800-375-1406 (toll free)
1-573-751-3425 (local)
1-800-735-2966 (TYY)
www.morx.mo.gov

MONTANA SPAP
Big Sky RX Program
P.O. Box 202915
Helena MT 59620-2915
1-866-369-1233 (toll free- In State)
1-406-444-1233 (local)
711 (TTY)
http://www.dphhs.mt.gov/prescriptiondrug/bigsky.shtml

NORTH CAROLINA SPAP
NCRx
P.O. Box 10068
Raleigh NC 27690-2724
1-888-488-6279 (toll free)
www.ncrx.gov

NEW JERSEY SPAP
New Jersey Senior Gold Prescription Discount Program
New Jersey Department of Health and Senior Services
P.O. Box 724
Trenton NJ 08625-0360
1-800-792-9745 (toll free)
1-609-292-7837 (local)
http://www.state.nj.us/health/seniorbenefits/seniorgold.shtml

NEW JERSEY SPAP
New Jersey Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)
PAAD-HAAAD
P.O. Box 715
Trenton NJ 08625
1-800-792-9745 (toll free)
1-609-292-7837 (local)
http://www.state.nj.us/health/seniorbenefits/paad.shtml

NEVADA SPAP
Nevada Senior Rx
Nevada Senior Rx Dept of Humana Resources
4126 Technology Way, Suite 101
Carson City NV 89706
1-866-303-6323 (toll free)
1-775-687-4210.option 7 (local)
http://dhhs.nv.gov/SeniorRx.htm

NEVADA SPAP
Nevada Disability Rx Program
Department of Human Resources
3416 Goni Road, Suite D-132
Carson City NV 89706
1-866-303-6323 (toll free)
1-775-687-7555 (local)
http://dhhs.nv.gov/disabilityRx.htm

NEW YORK SPAP
New York State Elderly Pharmaceutical Insurance Coverage (EPIC)
P.O. Box 15018
Albany NY 12212-5018
1-800-332-3742 (toll free)
1-800-290-9138 (TTY)
http://www.health.state.ny.us/health_care/epic/index.htm

PENNSYLVANIA SPAP
Pharmaceutical Assistance Contract for the Elderly (PACE)
1st. Health Services, 4000 Crums Mill Road
Suite 301
Harrisburg PA 17112
1-800-225-7223 (toll free)
1-717-651-3600 (local)
1-800-222-9004 (TTY)
http://www.aging.state.pa.us/portal/server.pt/community/pace___pacenet/17944

RHODE ISLAND SPAP
Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)
Attention RIPAE
John O. Pastore Center
Benjamin Rush, Building 55
35 Howard Avenue
Cranston RI 02920
1-401-462-3000 (local)
1-401-462-0740 (TTY)
http://www.dea.state.ri.us/programs/prescription_assist.php

SOUTH CAROLINA SPAP
South Carolina Gap Assistance Pharmacy Program for Seniors (GAPS)
P.O. Box 8206
Columbia SC 29202
1-888-549-0820 (toll free)
1-803-898-2500 (local)
http://www.dhhs.state.sc.us/dhhsnew/insidedhhs/bureaus/bureauofeligibilityprocessing/silverxcard.asp

TEXAS SPAP
Texas Kidney Health Care Program (KHC)
Department of State Health Services MC 1938
P.O. Box 149347
Austin TX 78714
1-800-222-3986 (toll free)
1-512-458-7150 (local)
1-800-735-2989 (TTY)
http://www.dshs.state.tx.us/kidney/default.shtm

VERMONT SPAP
Vermont V-Pharm
312 Hurricane Lane
Suite 201
Willston VT 05495
1-800-250-8427 (toll free)
1-888-834-7898 (TTY)
http://www.q1medicare.com/PartD-SPAPVermontVPharmVHAPPharVSCRIPT.php

WASHINGTON SPAP
Washington State Health Insurance Pharmacy Assistance Program
P.O. Box 1090
Great Bend KS 67530
1-800-877-5187 (toll free)
https://www.wship.org/Default.asp

WISCONSIN SPAP
Wisconsin SeniorCare
PO Box 6710
Madison WI 53716
1-800-657-2038 (toll free)
1-608-266-1865 (local)
1-888-701-1251 (TYY)
http://www.dhs.wisconsin.gov/seniorcare/index.htm